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**COUNSELLING BY HEALTH VISITORS
IN THE TREATMENT OF
POSTNATAL DEPRESSION**

Jenifer M. Holden

**MASTER OF PHILOSOPHY
UNIVERSITY OF EDINBURGH**

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ABSTRACT

A randomised controlled trial of counselling by health visitors was conducted in health centres in Edinburgh and Livingston. Standardised measures of psychiatric morbidity were used to identify sixty women who were suffering from depression at about thirteen weeks postnatal. Fifty-five women gave their informed consent to participation in the trial, and were allocated using random numbers to the treatment group or a control group. Seventeen health visitors were given a brief training in methods of non-directive counselling, and were asked to pay eight consecutive weekly visits to women in the treatment group. Fifty women completed the trial.

After a mean time interval of thirteen weeks, the women were re-interviewed, using the same measures of depression. The interviewer did not know to which group the mother had been assigned. The percentages of women who had recovered in the counselled and control groups were 69.2% and 37.5% respectively. The difference, 31.7%, had a 95% confidence interval of 5% to 58%. The Chi squared statistic was 5.06, with an associated P value of 0.03.

Although confidence in the robustness of these findings must be tempered by the small numbers in the trial, the superior rate of recovery of women in the treatment group is encouraging. Implications for the training of health visitors, in particular for the development of listening skills are discussed.

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INTRODUCTION

"...I enjoyed my pregnancy and I enjoyed having him, it was the greatest thing I have ever experienced until I came home. And then I thought, God, I dinnae want you... It was lonely... I felt as if I was inside this box, just all by myself, wi naebody to help me, or to help me understand why I was like this... I have been sad before and I have been unhappy, but never like after I had Thomas, to the point where I just didn't want to live any mair..."

This excerpt from a transcribed interview with a mother in this study will have a familiar ring to any member of the caring professions who has had close contact with mothers in the weeks or months following delivery. The despair felt by many young mothers is in direct contrast to their anticipation of the joys of motherhood. Susan had no previous experience of depression, was happily married with no financial or housing worries, had planned her pregnancy, attended antenatal classes and looked forward eagerly to the birth of her baby. What went wrong, and what should be done about it? Is her case an unusual one?

There is some justification for the complaint by those experiencing postnatal depression that their condition has not been taken seriously by the medical profession. Although mental illnesses associated with childbirth were first noted by Greek physicians, and were fully described by Marce and Esquirol in the nineteenth century, they have been comparatively neglected until recent years. Hamilton (1982) explains that with the adoption of the Kraepelian classification system early this century, postpartum psychosis was removed from the list of recognised psychiatric disorders, and along with it the idea of an association between mental disturbance and the event of birth. Hamilton believes that the resulting distribution of cases of mental illness associated with childbirth into other categories led to a lack of medical education on the subject, with the result that many physicians are poorly qualified to deal with psychiatric problems arising in the puerperium. The concept of postnatal mental disturbances as deserving of attention and treatment is therefore relatively recent. In fact, the first statistical study was done by Ralph S. Paffenbarger in 1961. A growing interest by psychiatrists, psychologists and others over the following years led to the setting up of the International Marce Society in 1980 specifically to conduct research and gather information on the subject.

The definition 'Postnatal Depression' is sometimes used rather loosely and it may be useful to look briefly at other categories of puerperal mental disturbance in order to clarify my use of the term. In the next section I will outline the "blues" and puerperal psychoses, followed by a more comprehensive review of recent research findings in the field of postnatal depression.

The "blues"

The most commonly occurring emotional disturbance after childbirth is the "blues" which affects over 50% of all mothers during the period immediately following delivery, (Cox, 1986). Mothers typically have unexplained changes of mood, elation being followed by weeping for apparently trivial causes. Lack of evidence for an association between blues and obstetric factors, social class, marital status or other personal and environmental factors, combined with its high prevalence, suggests a biological cause, the dramatic change in hormone secretion level following delivery being proposed as a major precipitating factor.

The search for a direct causal link has, however, so far proved inconclusive. Handley et al (1977) suggested that plasma levels of tryptophan and tyrosine may be affected by changes in steroid hormone status after childbirth. However, Harris (1980) showed that treatment with L-tryptophan did not alleviate symptoms of the blues, and concluded that tryptophan levels are not related to this syndrome. In 1982, Nott and his colleagues, who studied plasma hormone assays in 27 women pre and post-delivery found no strong relationships between hormone levels and mood changes, except that the greater the drop in plasma progesterone after delivery, the higher the risk of depressive symptoms. On the other hand, Kuevi et al (1983) who investigated the relationship between hormone levels, plasma catecholamines and mood disturbances in 44 women during days 2-5 postpartum found that although 52% of their sample had periods of emotional lability, there was no significant correlation between plasma concentrations of FSH, prolactin, oestrone, oestradiol, cortisol or progesterone and the incidence of postpartum blues. Stein (1982) considered that there may be an interaction between susceptibility and the chemistry of birth mechanisms; she suggests that the blues may resemble the premenstrual syndrome in that individual differences in symptoms may have genetic or environmental influences, but that physiological changes in the early puerperium in some way result in their manifestation.

Pitt (1973) devised a self-rating scale for the blues, utilising the eight symptoms described by Hamilton (1962) as being most frequent. (Weeping, depression, insomnia, headache, anxiety, confusion, fatigue, hypochondriasis and antagonism to the husband). From descriptive accounts of the blues Stein (1980) discerned two components which she believes may have separate causes. The first is a distinct episode which occurs between the third and tenth day, characterised by weeping, and the second is a cluster of symptoms including depression, irritability, tension, confusion, anxiety, restlessness, depersonalisation and insomnia, which occur with varying severity in different combinations in each individual. Although the blues has been extensively studied (Haas, 1952, Moloney, 1952, Yalom et al, 1968, Pitt, 1973, Stein, 1976, 1980, George, 1981), there is no agreement about when the incidence of the blues is highest; dysphoric episodes can occur on almost any day during the first 10 days or more.

The blues is usually dismissed as a short, time-limited disorder, but although it so common as to be almost the norm, Stein warns that not all women conform to Pitt's (1973) stereotype of a "trivial, fleeting phenomenon", and suggests that some women have severe reactions which should perhaps be classified separately. As Kendell (1985) pointed out, the fact that timing of the blues coincides with timing of the the onset of most puerperal psychoses suggests that whatever trigger mechanism is responsible for the blues may also precipitate psychosis in predisposed women. We can conclude that the emotional response of all women in the days following childbirth should therefore be carefully monitored.

Puerperal psychosis

At the other end of the scale is puerperal psychosis, which is dramatic in onset and intensity, the patient's bizarre behaviour being easily recognised as requiring psychiatric treatment. Although only 2-3 in each thousand women who give birth will develop puerperal psychosis, studies over the past 20 years show that this proportion is startlingly high when compared with the likelihood of psychiatric illness at other times of life. From a survey of 13 studies conducted since 1913, Thomas and Gordon (1959) described the sudden and short-lived rise in the incidence of psychosis after childbirth as having the characteristics of a "point epidemic" and these earlier findings have been sustained. In 1966, Paffenbarger found that 18 times more women in Ohio were admitted to mental hospitals in the month following childbirth than at any other time, and an extensive Edinburgh study by Dean and Kendell (1981), who used the Edinburgh Case Register to identify all women admitted to mental hospitals within 90 days of delivery between 1971 and 1978, confirmed that there is dramatic peak of psychiatric hospital admissions at this time.

Whether this increased incidence is due to an illness specific to the puerperium, or simply to more women being precipitated into illness by the stress of childbirth is unclear. Two early studies (Foundeur et al., 1957, Protheroe, 1969) concluded that puerperal illnesses were no different from those occurring at other times. Nevertheless, the concept of a specific disorder is still debated. Dean and Kendell (1981) found no differences in treatment, response or length of hospitalisation between puerperal and nonpuerperal psychotic women, and concluded that although the evidence suggests that most functional disorders occurring in the puerperium are the same as those occurring at other times, the possibility of some cases being specific to the puerperium has not been excluded. Hamilton (1982) argued that although psychiatric illnesses occurring after childbirth do not fit neatly into a defined category, postpartum psychiatric illness has many features which distinguish it from non-puerperal psychiatric illness.

Debate about the origins of puerperal psychosis has been inconclusive. In 1969 Protheroe found that parents and siblings of women with puerperal affective disorder showed a similarly increased morbidity risk to that of first degree relatives of patients with manic-depressive disorder. However, Whalley and his colleagues (1982) found that genetic markers did not distinguish puerperal from non-puerperal psychoses. While Paffenbarger (1964), favoured a somatic explanation, Kendell (1985) concluded from reviewing the literature that obstetric factors have surprisingly little influence on the risk of psychosis. Neither does research into the psychological stress of childbirth provide a clear answer. Kendell al (1981) who found that having a first baby, being unmarried and undergoing Caesarian Section were all associated with increased risk, while twin births, perinatal death and maternal age were not, argued that since not all indices of psychological stress were related to increased risk, and since the risk of psychosis following childbirth is considerably higher than that attributable to other life events, the psychological stress of childbirth does not fully explain the increased incidence. In his lucid review, Kendell also pointed out that the birth of a child is also a stressful "life event" for fathers. This is presumably not reflected in increased psychiatric admissions for men following the birth of their child.

Categorisation also presents problems. As Hamilton (1982) pointed out, puerperal psychosis can variously present as depression, mania, delirium or with schizophrenia-like delusions and aberrant thinking. However, Brockington, (1982) suggested that puerperal psychosis has been defined too broadly. Perhaps the clearest study of the epidemiology of puerperal psychosis comes from an exhaustive computer-linked epidemiological study by Kendell, Chalmers and Platz (1987). They showed that women with a history of manic depressive disorder had a much higher risk of admission in the puerperium than those with a history of schizophrenia or depressive neuroses, and that the majority of puerperal admissions met Research Diagnostic Criteria for manic or depressive disorder, and concluded: "probably, therefore, puerperal psychoses are manic depressive illnesses, and unrelated to schizophrenia".

Whatever their origin, there is a general consensus that with modern treatments, the puerperal psychoses have an excellent prognosis.

Postnatal depression

The postnatal depression discussed here, although more severe and longer-lasting than the blues, is of a less dramatic nature than the puerperal psychoses, and for that reason diagnosis is more likely to be missed. It is generally considered to be a neurotic disorder with a more gradual onset and before six weeks after birth is not easily distinguished from the fatigue and emotional lability experienced by most mothers as they recover from the delivery and adjust to the demands of the new baby. However, without help and treatment, the mother with a 'mild' depression may take the downward spiral into chronic and long-lasting disability, which may cloud not only her own life, but also that of her husband and children.

Incidence of postnatal depression

As Kendell (1985) points out, non-psychotic puerperal depression has only begun to attract the attention of researchers during the last 20 years. Although methodology and criteria for defining depression and the timing of assessments have varied, conclusions as to the incidence have been similar. The first influential study to examine depression occurring in non-hospitalised women following childbirth was by Brice Pitt in 1968. Using a questionnaire based on his psychiatric experience and also the Hamilton rating for depression, administered at 28 weeks antenatally and at six weeks and one year postnatally, Pitt found 11% of 330 women to be depressed six weeks after delivery. His criteria were:

- 1) Subjects should describe depressive symptoms.
- 2) These symptoms should have developed since delivery.
- 3) These symptoms should be unusual in their experience, and to some extent, disabling.
- 4) The symptoms should have persisted for more than two weeks.

This study served as a model for subsequent research, and in studies using similarly strict criteria, the incidence is remarkably consistent, varying between 10%-16%. Kumar and Robson (1978), who used the Goldberg Standardised Psychiatric Interview as the criterion for depression, found an incidence of 12% in a sample of 119 women, and Wolkind et al (1980), using a psychiatric interview found 10% of 113 primiparae to be depressed at 4 months postnatal. In Edinburgh, Cox et al (1982) found that 13% of 103 women followed through from an antenatal clinic suffered from depression 3-5 months following delivery, and 16% of Watson et al's sample of 128 women were depressed at 6 weeks postnatal (1984). Both these studies used Goldberg's psychiatric interview.

How long does postnatal depression last?

Depression occurring after childbirth has often been considered as a short, self-limiting condition, and as such, not in need of specific treatment. However, such depressions are often persistent. Pitt (1968) observed that 12 out of the 28 depressed women followed up a year after delivery were still depressed (43%). Similarly, Cox and his

colleagues (1984) found that at least half of the depressed mothers in their study had not recovered by the end of the first postnatal year. Of 16 new cases of depression which were detected 12 weeks after delivery by Kumar and Robson (1984), 8 were still depressed at 6 months. 7 of the 15 women with postnatal affective disorder in Watson's 1984 study reported depressions with postnatal onset which lasted more than six months, and many continued to experience psychological problems for up to four years following childbirth.

Other long-term follow-up studies indicate that women who become depressed postnatally are more likely to report depression over the subsequent years and especially following subsequent deliveries. (Uddenberg and Engleson, 1978, Kumar and Robson, 1984, Wolkind et al, 1980 and 1984, and Wrate et al, 1985). However, it is not yet clear whether this persistent susceptibility to depression is a direct consequence of postnatal depression or simply a manifestation of a pre-existing vulnerability. Zajicek and Wolkind (1978) found that 14% of their total sample showed emotional disturbance at some point during the antenatal and postnatal period. One-third of this group were depressed before pregnancy, during pregnancy and after delivery, and were still depressed at fourteen months postnatal. Zajicek and Wolkind suggest that this continuity of emotional reaction may reflect a personality trait or early psychological trauma.

It has been suggested that the mood changes following childbirth may be on a continuum, the blues turning into "neurotic" depression, which, if untreated, may in turn develop into a major depressive psychosis. (Nott et al, 1976, Stein, 1982, Cox, 1986). Pitt noted an association between the blues and postnatal depression which was replicated in a few of the subsequent studies. For example, in a widespread study carried out by 64 general practitioners working in the British Isles, Playfair and Gowers, (1981) found severe postpartum blues to be among the predictors of postnatal depression, and Paykel et al (1980) and Kendell et al (1981) found a similar association. However, as the majority of women experience the blues, it cannot be considered as a very useful predictor of postnatal depression, although women experiencing severe symptoms should be carefully monitored (Cox, 1986).

How severe is postnatal depression?

Although it may be true that relatively few mothers with postnatal depression will require psychiatric intervention, and some depressions may remit spontaneously after weeks rather than months, (Snaith, 1983) this does not mean that it can be dismissed lightly. Pitt gives an overall description of the quality of the experience from interviews with 27 of his 33 depressed subjects. The depression, which commonly started after return from hospital, was characterised by:

...tearfulness, despondency, feelings of inadequacy and inability to cope, particularly with the baby... Guilt was confined to self-reproach over not loving or caring enough for the baby...

....excessive anxiety over the baby which was not justified by the babies' health... Unusual irritability was common, sometimes adding to feelings of guilt... a few patients complained of impaired concentration and memory, and undue fatigue and ready exhaustion were frequent, so that mothers could barely deal with their babies, let alone look after the rest of the family and cope with housework and shopping... Anorexia was present with remarkable consistence, and sleep disturbances, over and above that inevitable with a new baby, were reported by a third of the patients, taking the form of difficulty in getting off to sleep, rather than early morning waking. (Pitt, 1968)

Pitt's vivid description clearly reveals the suffering caused to the mother, and intimates possible disturbing effects on the mother-infant relationship. This possibility will be discussed later.

That postnatal depression is a significantly traumatic experience for the mother herself has been clearly demonstrated by the setting up of self-help groups such as the Association for Postnatal Illness, which has branches in London and Glasgow. Esther Rantzen's frank discussion on television of her own postnatal depression did much to publicise the subject, and several books have recently been published in the 'popular' press. "The New Mother Syndrome" is a carefully researched book by journalist by Carol Dix (1985) and was also the consequence of personal experience. Dix reviews the history and theoretical background to postnatal depression, presents descriptive material from interviews with sufferers, and suggests possible causes and ways in which mothers can be helped.

In Vivienne Welburn's book, "Postnatal Depression" (Welburn, 1980) which was also provoked by her own experience, she explains postnatal depression as a socially induced phenomenon, and sees some of the contributing factors as being lack of social support for mothers in our culture, the isolation induced by the nuclear family; the low status accorded to motherhood in society today; the increasing mechanisation of labour; and the low priority placed by obstetricians and the medical profession on the psychological health of mothers.

Both these authors cite numerous cases in which women went through a traumatic experience with no knowledge of what was happening to them and obtained little, if any, help from professionals. To be depressed after having a baby can be desperately lonely and alienating. To feel that one is no longer in control of one's emotions, and therefore of one's day-to-day life can be an overwhelming and even a terrifying experience, especially if it seems that no one understands. Maternal depression can also affect the whole quality of family life, and although as yet the long-term consequences of postnatal depression have not been extensively studied, there are strong indications that it may have considerable effects on the intellectual, social and emotional development of children, which will be discussed later.

WHAT "CAUSES" POSTNATAL DEPRESSION?

Although postnatal depression is frequently discussed in terms of an "illness" specific to the period following childbirth, there is no straightforward explanation as to its genesis. At the time of Pitt's study, the endogenous - reactive argument was in full swing, and postnatal depression has revived the "illness" versus "reaction-to-events" argument. However, there is some lack of agreement as to the correlates of postnatal depression, partly because different variables have been chosen by researchers.

Biological factors

The attraction of a biological explanation for postnatal depression is apparent. If, as Dalton (1980) has suggested, postnatal depression was directly related to a sensitivity to changes in hormone levels, depressed mothers could be simply treated with hormonal adjustment therapy. Research directed towards resolving this argument has, however, proved inconclusive. For example, a recent extensive study in America (O'Hara 1987) did not show any difference in hormone levels between depressed mothers who had recently given birth and other depressed women matched for age, social status and number of children.

Watson, Elliott, Rugg and Brough (1984) believed that a biological explanation could only explain a minority of cases of postnatal depression. They found that there was little to distinguish groups of women experiencing affective disorder in the puerperium from those experiencing it at other times. The case histories of only two out of fifteen women with affective disorder six weeks after delivery showed no psychosocial reasons (for instance a less-than-satisfactory marital relationship) for their being depressed.

Obstetric factors

As with puerperal psychosis, obstetric factors do not appear to correlate closely with postnatal depression, although Kendell et al (1981), and Nott (1982) found an association with Caesarian section in psychotic women. Pitt found obstetric factors to be irrelevant, in fact there was a negative relationship with toxæmia and other obstetric complications. Similarly, Paykel (1980) found a significant negative correlation between postnatal depression and the complications of labour.

Psychosocial factors.

Although research into predictive factors for postnatal depression has not produced any clear consensus, the evidence so far seems to suggest that the majority of cases of postnatal depression may have psychosocial rather than physical origins. Contributing factors found in various studies include a poor relationship with the partner, lack of social support, lack of parenting in childhood or a current poor relationship with one's mother, ambivalent feelings about motherhood, previous stillbirth, poor housing, or a recent stressful life event.

Sometimes depression can be seen as a grief response. Kumar and Robson found that bereavement and preterm birth were the only life events to relate with the onset of depression. The birth of the new baby may reawaken unresolved grief for a previous distressing event such as a miscarriage, abortion or stillbirth. Cox et al (1982), Watson and Elliott (1984) and Kumar and Robson (1984) all found such associations, and severe doubts about having the present baby were also associated.

In their study of women in the community Brown and Harris (1978) showed that stressful life events can lead to depression. Such factors may include recent bereavement or loss, a family crisis, loss of a job, a recent change of house or even bad relationships with neighbours, and new mothers may be particularly vulnerable to such events. Paykel (1980) and his colleagues found that the strongest factor associated with postnatal depression was a recent stressful life event, poor marital support being associated only if this accompanied such an event. However, they also found that the "blues" were associated with depression only in the absence of a serious life event, and concluded that depression in a small sub-group of postnatal women may be hormonally based. Overall, however, this research emphasised the importance of social stress in relationship to postnatal depression.

Watson et al (1984) also found that the majority of episodes of affective disorder at this time could be understood in terms of reaction to life events, including the stress of childbirth itself.

Previous depression

Many researchers have found an association between postnatal depression and a history of psychiatric disorder, including Tod (1964), Martin (1977), Ballinger (1979), Paykel et al (1980), Watson et al (1984) Playfair and Gowers, 1981, and Cox et al (1982) ("Always been a worrier"). A history of depression in one's immediate family makes a depressive response to stress more likely, but whether this is due to genetic factors, behaviour learned by role modelling, or the effect of living in a depressed environment has not yet been explained. Having been previously depressed oneself, (particularly if this followed the birth of a baby) does seem to increase the likelihood that depression will occur after subsequent deliveries.

O'Hara et al (1983) found that the number of previous depressions and depression in first-degree relatives were the only two significant factors in vulnerability to depression, suggesting that postnatal depression is related to depression occurring at other times. They hypothesise that this may indicate a social learning or genetic contribution from the family.

Cognitive factors

The cognitive-behavioural models of Abramson, Seligman and Teasdale (1978) and Lewinsohn et al (1979) all suggest that psychological vulnerability may lead to depression. For example, a depressive response is particularly likely in someone whose previous experience of life has led them to believe that external circumstances are controlling forces over which they have no influence. Such individuals have a tendency to view stressful events and difficulties as major, aversive, uncontrollable, and an indication of personal failure. (The 'internal, stable, global' attributions of Abramson et al, 1978). According to Garnezy (1983), learned helplessness can be seen as: "the language of failure, of disability and of self-perceived incompetence", which may be unrelated to actual abilities and circumstances.

[Seligman's original theory of learned helplessness was derived from experiments in which animals (and later, humans) were subjected to situations in which they could not control the occurrence of either pleasurable or aversive events (Seligman, 1975). In subsequent trials in which subjects could control the occurrence of these events, they made no attempts to do so].

O'Hara et al (1982) hypothesised that the learned helplessness model and theoretical constructs related to behavioural (Beck, 1972) and self-control theory (Rehm, 1977), measured during pregnancy could be used to predict depression postpartum. They also rated social adjustment and personal life stress, and found that antenatal depression, attributional style, and delivery stress were all significant predictors of depression after childbirth. They concluded that their findings underline the extent to which depressive symptomatology is multiply determined.

Vulnerability

Vulnerability to future psychopathology starts with early experiences. Frommer and O'Shea (1973) considered the effect of parental deprivation in childhood on mothering. Women who reported being separated from one or both parents before the age of eleven had a higher incidence of depression and were more anxious about their babies than non-separated women. Bifulco and Brown (1987), found that women whose mother died or was absent during their childhood, without an adequate substitute carer being available were more vulnerable to depression in adulthood, although his was not a postnatal sample.

As has been already discussed, an important protection against depression is to have a close and confiding relationship. Campbell et al (1983) found that the lack of an intimate relationship with husband or boyfriend increased the risk of psychiatric disorder in the face of a provoking agent. However, not all single mothers become depressed, neither do all women with partners, however caring, escape depression.

What is important is that one should have someone understanding in whom to confide on a regular basis, especially in times of stress. Cutrona and Troutman (1986) reported that at three months postnatal, social support appeared to exert a protective function against depression.

A Multifactorial explanation

Looking at the rate of psychiatric disorder in children, Rutter (1979) found this to be a function of the number of risk factors to which they had been exposed. A single stress, even when chronic, had no lasting ill effect. Similarly, the accumulating evidence from research into the possible precipitating factors which lead to depression in the postnatal period suggests a multifactorial explanation; childbirth may be the final stress factor for women who are already vulnerable to depression, particularly for someone who feels that they have no control over their circumstances.

When Elliott (1984), subjected the test scores of women who took part in Watson et al's longitudinal study (1982) to detailed analysis she revealed a complexity of psychological responses to childbirth. She believed that her data do not indicate that postnatal women can be neatly classified as being either "normal" or as suffering from "atypical depression". In place of this dichotomy, she envisages the emotional after-effects of childbirth as being on a continuum, preferring the concept of multidimensionality to a single depressed/not-depressed classification. Her suggested model is: "a description of all that is known about psychological experience during pregnancy and the first postnatal year", an approach which encompasses individual differences in both experiences and responses to experience. Zajicek (1981) concluded that in response to any new role transition in adult life: .

"...some people find that it fulfills their needs and feel positively motivated towards it, while others feel frustrated and overwhelmed by demands with which they feel unable to cope. The problems with pregnancy and motherhood are that expectations are much greater. Women are assumed to have a biological inclination to become mothers which is supposed, in the end, to overcome all other basic inclinations".

For many women, especially those whose nature and experience has rendered them vulnerable, the loneliness and responsibility of having to care for a small baby and also maintain a loving relationship with one's partner and perhaps one's other children can be overwhelming. Exhaustion and constantly wondering "am I doing it right?" (in comparison with the stereotype picture of maternal bliss presented by the media) can lead to chronic irritability compounded by guilt - a vicious circle which drives the partner away.

THE EFFECTS OF MATERNAL DEPRESSION ON CHILDREN

Winnicott (1957) and Bowlby, (1953) pointed out the importance of the early relationship between mother and baby in the infant's subsequent psychological development. Trevarthen (1980) developed a theory of intersubjectivity, believing that it was the infant who led the relationship. Using videotaped sequences of interactions, Trevarthen demonstrated the relationship between a mother's ability to respond closely to minute cues from her infant with the development of communication skills in her baby. Carrying this work a stage further, Lynne Murray, (1988) has recently reported differences in videotaped mother-infant interactions between depressed and non-depressed mothers. In one of the experimental conditions the infant is unable to elicit a response from the mother, and babies typically react to this condition with avoidance. During a period of "normal" interaction with his mother, one eight-week old baby showed all the behaviours usually associated with the experimental period of unresponsiveness in the mother to an extreme degree. Only later was this mother diagnosed as clinically depressed. According to Murray, such disturbed behaviours in the infant represent an adaptation to being with a depressed or unresponsive mother, and may be resistant to change when the mother is herself ready or able to engage in affectionate contact. She believes they: "may become overgeneralised or fixed, thus limiting subsequent experience".

Confirmation for Murray's hypothesis of a lasting effect on babies of the mother's depression comes from an ongoing study by Alan Stein (Cooper et al, in press). Stein found that 19 month olds whose mothers were depressed during the first postnatal year showed less concentration and more negative responses than control group babies, were more likely to exhibit distress at the mother's departure and to be less sociable with strangers.

Rutter (1985) observed that among the important influences on a child's early cognitive development are the provision by parents of a variety of activities and opportunities for play and conversation, responsiveness to the child's signals, and the teaching of specific skills. For mothers with postnatal depression, lowered levels of communicating with their infants may lead to early problems in developing language, and later to reading difficulties. In a longitudinal study of maternal mental health during pregnancy and after delivery (Kumar and Robson, 1984), the cognitive function of the first-born children of 94 women was tested at age 4 using the McCarthy Scale (Cogill et al, 1986). Significant intellectual deficits were found in children whose mothers had suffered depression during the first year of the child's life.

Mothers with postnatal depression may also have toddlers to look after. Several studies have demonstrated the effect of maternal depression on pre-schoolers. Although they were not looking directly

at postnatal depression, Richman, Stevenson and Graham (1982) report that 75% of children with IQ-corrected reading retardation at age 8 had mothers who were depressed when the child was aged 3. Wolkind and de Salis (1982), Kruk and Wolkind (1983), as well as Richman (1978), clearly demonstrated a strong association between maternal depression and disturbance in pre-school children. Similarly, Pound et al (1985) found that 44% of 2-3 year-olds whose mother was depressed had marked behaviour problems. In a longitudinal study of postnatal depression, Wrate et al (1985), who used the Child Behavioural Checklist (Richman and Graham, 1971) also found more behavioural problems in the three-year-old children of mothers who had been depressed postnally than in the children of control group mothers. Uddenberg and Englessen in Sweden (1978) found an association between postnatal mental disturbance and a mother's tendency to describe her four and a half-year old child in a negative way. (Their children also described the mother more negatively^o).

Robson and Kumar, 1980, found that mothers who were depressed three months after delivery were more likely to express dislike or indifference towards their babies. However, it may be possible that babies have an effect on their mother's mood. Cutrona and Troutman found that infant temperamental difficulty was strongly related to the mother's level of depression at three months postpartum.

From this accumulating evidence, it seems clear that maternal depression does indeed affect the development of small children, and that these negative effects are not transient. Children are not the only members of the family to be affected, however, and in the following section I will discuss the relationship between the mother and her partner with respect to postnatal depression.

INTERPARENTAL RELATIONSHIPS AND POSTNATAL DEPRESSION

Pregnancy, birth and the care of children have traditionally been regarded as the mother's role, fathers being seen as responsible for providing the material needs of the family. Winnicott (1957) saw the father merely as the facilitator of the mother's intense involvement with her child; it was sufficient for him: "to be alive and stay alive during his child's early years". For Bowlby also (1953), the father was: "of no direct importance to the young child". However, the importance of the parental relationship in the emotional stability of the family is receiving increasing recognition, and evidence is emerging which suggests that husbands play a significant role in their wives' psychological wellbeing during childbearing and parenthood.

Brown and Harris (1978), who looked at depression in women from a sociological standpoint, found that women who have a confiding relationship with their partner are less likely to become depressed. Several studies have shown an association between lack of support or confiding in the marital relationship (or actual marital disharmony) and postnatal depression (Nilson and Almgren, 1970, Paykel et al, 1980, Cox et al, 1980, Playfair and Gowers, 1981, Kumar and Robson, 1978, 1984, and Watson et al, 1984). However, in most of these studies the relationship was assessed during pregnancy, with a view to establishing whether having a poor relationship leads to depression after the baby is born. To date no one seems to have examined the extent to which the mother's depression may itself affect the relationship.

O'Hara (1985) who assessed depression and marital satisfaction in 51 women and their partners found that depression increased in both husband and wife during pregnancy and after delivery, and that there was a significant correlation between the wife's and her husband's depression. This study clearly shows that childbirth is a stressful event for both parents, although it is not clear whether the wife's depression had an effect on the husband or vice versa. Wolkind and Zajicek (1981) expressed concern about the possibility of husbands being ill prepared for the loss of closeness caused by the arrival of the baby, particularly the first. They may be even less prepared for the alienation caused by postnatal depression.

Pitt first described the intense irritability directed particularly towards the husband, which was in his opinion the symptom which most clearly distinguished postnatal from depression at other times. This irritability may be interpreted by the husband as hostility rather than a signal that help is needed.

"It is terrible, you cannae dae naething, no matter what you do, you are wrong, and it is hard to explain, but you are never right. She is awfy quick tempered, things that normally she would laugh about, she disnae. She has changed a lot. You sometimes say to yourself...is she tired of me, is she sick of me, well you do."

The above quotation from a transcribed interview with the partner of one of the depressed women in the present study was so typical as to be almost a stereotype, and illustrates the disruptive effect that postnatal depression may have on the marital relationship. Gordon, Kapostins and Gordon (1965) looked at ways to help women avoid emotional problems after the birth. Women who were encouraged during pregnancy to confide in their husband and enlist his practical help did get more help and were less likely to have emotional problems after delivery. Whether this approach would be effective after depression is established is unclear. Confiding when one is depressed is not easy; even if she wants to explain, the mother is often as confused by her own behaviour as is her partner, and may find it as difficult to ask for the extra help and affection she needs as it is for her partner to give it.

Paykel et al (1980) showed that a confiding relationship is less likely when the mother is depressed. 20% of a sample of 120 women were rated as depressed between the sixth and eighth week postnatal. Paykel et al rated the women's perception of the extent to which they could tell their husband their worries and problems, and the extent to which he would listen or avoid, and found that the depressed women had significantly worse ratings. However, it is not known whether difficulties in communication contributed to the depression, or whether the depression itself made communication difficult.

Living with anyone who is depressed calls for tolerance and the demonstration of continued caring, as well as practical help. For a couple who are also trying to adjust to the changes a new baby has brought into their lives, the stress on the relationship may be tremendous. I end this section with another quotation from a father interviewed in the present study:

"...if I was working, and I had a wage on a Friday night, I wouldnae come hame here. I'd go to pubs, discos and that. And if I went with another woman I'd go home with her. It's as simple as that. And I wouldnae feel any guilt, whatever. Because I'm no getting any love or affection at home. It was great before the baby came. But now I'd be as well being a monk. I never even get a cuddle off her. Sex matters in a marriage. Well, it does, it's nine- tenths of a marriage...is sex...and, well, love. That's it. And if you dinnae get it, naebody's going to stay in the house".

TREATMENT

There have been few studies on the treatment of postnatal depression, although some researchers have aimed at prevention by education. Gordon and Gordon (1960) found that women who were encouraged to elicit help from their spouse had less emotional problems after delivery, especially if their partner attended the classes. Sheresefsky and Lockman (1973) who gave antenatal counselling about adaptation to parenting, found that marital relationships in their control group deteriorated by 6 mths postpartum, compared to that of counselled women.

1) Medical treatment.

Paykel (1980) and Snaith (1983) hypothesised that a small group of cases of postnatal depression may be biogenic in origin. Snaith recommended that antidepressants should be prescribed in cases of persistent anhedonia with a definite time onset, followed by psychiatric referral if recovery is not complete. Snaith argues that haste in prescribing treatment should be avoided, especially sedatives; benzodiazepines may have the paradoxical effect of increased irritability, which may convert a potential into an actual baby batterer. Kumar (1982) pointed out that much clearer guidelines are needed about the indications and contraindications for prescribing psychotropic drugs for pregnant and lactating women, and suggested that studies of treatment should extend beyond physical treatments.

2) Hormone treatment.

Katarina Dalton (1980), who is of the biogenic school, believes that there is a direct connection between premenstrual tension and subsequent postnatal depression which she, like Pitt, views as "atypical". She prescribes daily progesterone injections for high-risk women to be given from the onset of labour for the following eight days, combined with monoamine oxidase inhibitors, and bromocryptine to suppress lactation in non-breast-feeding women. However it has been pointed out that the efficacy of such vigorous treatment has not yet been subjected to empirical tests (Kumar, 1982, Elliott, 1984).

Pyridoxine

Diana Riley (1987) has recently begun to investigate the use of pyridoxine, (vitamin B6) in the prevention of both the Blues and later depression in women who suffer from premenstrual tension. In a preliminary study (personal communication) less depression was reported at one month and one year in treated women. A controlled trial is underway.

Counselling

Riley and Snaith have also advocated counselling by health visitors for mothers with postnatal depression. It seems most likely that the provision of supportive counselling may be of benefit to women with postnatal depression, especially when combined with the possibility of referral to psychiatric services if required.

IDENTIFICATION

The first problem in treating postnatal depression is to find the women who are depressed. Although primary care workers have regular contact with mothers in the puerperium, Frommer and O'Shea (1978), Cox et al (1982) and Kumar and Robson (1984) all found that only rarely is postnatal depression recognised. For example, in Cox et al's prospective study of one hundred and three women in Edinburgh, none of the thirteen women who were found to have a marked postnatal depressive illness had received any sustained treatment from primary care workers, neither had they been referred for psychiatric help. The reasons for this lack of recognition may lie partly with the structures of existing service delivery and partly with the reluctance of mothers to confide.

Professionals themselves may miss postnatal depression unless they are actively looking for its presence. Many women, although they have identifiable clinical symptoms, are able to maintain an appearance of normality, their distress being apparent only within the family. To find out whether a mother is depressed takes time and the building up of a trusting relationship. Early contacts with mothers are usually structured to elicit information about the physical wellbeing of mother and infant; the prime objective of the midwife or doctor at the postnatal clinic being to check that everything is normal. Similarly, the health visitor may be preoccupied with the progress of the baby. Hennessy (1983) found that health visitors had only recognised 27% of mothers she identified as depressed. Only mothers who are obviously distressed or who volunteer the information that they are depressed are likely to be noticed. Most depressed women do not seek help; they may not realise that they need professional help, or that help is available. Or they may find it difficult to confide.

In an earlier study we devised a simple self-report scale (the EPDS: Cox, Holden and Sagovsky, 1987) which could be used in a health centre setting to screen mothers for postnatal depression. Health visitors who administered the scale found that it could be incorporated into clinic routine without disruption. The scale only takes only a few minutes to complete, and the health visitors found that giving the scale not only gave them the opportunity to display their interest in the woman's emotional state, but also gave women "permission" to reveal their feelings. The EPDS was used in the present study and will be described in more detail later.

RATIONALE FOR THE STUDY

After reviewing the literature, my conclusion was that depression after childbirth is more readily attributable to social and psychological factors than to an "illness" specifically caused by childbirth itself. Individual differences in present or past experiences or circumstances, genetic or learned vulnerability and "readiness" for motherhood may all contribute to the fact that some women become depressed while others do not. It may be that depression after childbirth is not dissimilar to that occurring at other times of life, and as the majority of women with postnatal depression seem to pass unnoticed by health professionals, it may even be considered that postnatal depression is a self-limiting condition not requiring treatment.

Why intervene?

To me, the question of whether postnatal depression is a specific type of depression unique to puerperal women seems to obscure the main issue. It does unarguably differ from depression occurring at other times of life in that its effects are being experienced at a time when exceptional physical and emotional demands are being made on the mother. The literature clearly shows that the period immediately following childbirth is of critical importance in the establishment of the relationship between mother and baby, and of the family as a harmonious and successfully functioning unit. The implications of depression for the mother herself are sufficient for it to merit special attention. If we also take into consideration the long-term harmful effects that depression at this time may have on the family unit, it can be seen that the early diagnosis and active treatment of postnatal depression should be a matter of the highest priority.

Choice of intervention.

Review of the literature indicated that the provision of a supportive listening service would be of benefit to mothers with postnatal depression for the following reasons. If postnatal depression has its roots in social deprivation then the provision of social support should be effective in reducing depression. Attributional style and other cognitive factors including "learned helplessness" and the belief that one has no control over events have also been shown to be associated with postnatal depression. (O'Hara et al, 1982). The knowledge that someone is there for us when we most need help can tip the balance between the feeling of being in control and loss of control; an enlightening study by Marshall Klaus showed that having a of a warm and caring person who stayed with the mother throughout labour not only reduced the time of labour by half, but dramatically reduced complications for both mother and baby. The availability of an understanding and supportive person during the stressful period of postnatal depression may be similarly effective.

The lack of a confiding relationship has been shown to be associated with postnatal depression (Campbell et al, 1983) and this also works the other way round; the presence of such a relationship has been shown to be an protective factor against depression. (Cutrona and Troutman, 1986, Gordon and Gordon, 1959). It is not unlikely therefore that the provision of a professional confidant may be effective in reducing depression.

Examining the coping process in her recent book "Reactions to Motherhood", Jean Ball concluded that "the person experiencing stress can be helped by someone whose unconditional support is available to them." Snaith (1983) stated that for the majority of women with postnatal depressive disorders, explanation, understanding and support would be of optimum benefit, and similar observations have been made by Elliott, 1984, Kumar and Robson, 1984, and Cox, 1986. In their account of the personal experience of depressed mothers Richard et al (1985) pointed out that what is most needed is support and someone to listen.

The beneficial effect of therapeutic listening was demonstrated to me during the course of a previous research project (development of the EPDS, Cox, Holden and Sagovsky, 1987). I asked women with postnatal depression what help they would most appreciate. The most frequent request was for the opportunity to talk to an understanding professional about their feelings. Women who were contacted after a diagnostic psychiatric interview spontaneously volunteered that they had felt much relieved.

Who should intervene?

Referral to community-based psychologists, community psychiatric nurses or counsellors may seem ideal. However, there are insufficient numbers of trained professionals to meet the needs of the one in ten mothers who become depressed. Also, many women may not wish to be referred for "treatment". It has already been shown that mothers are reluctant to consult, and they may fear the stigma that is still attached to psychiatric referral (Goldberg and Blackwell, 1970, Langer et al, 1974, Doherty, 1975).

Health visitors

Bergin (1974) has suggested that: "specially selected persons may provide adequate or better coping conditions for neurosis than do trained mental health experts". For various reasons we decided that health visitors should be suited to providing a counselling service. Although the majority of health visitors do not have a training in mental health, because of their nursing background and experience with clients, most already possess many of the qualities needed for successful counselling. Much of their time is spent in dealing with the problems of their clients, and their effectiveness is largely dependent on their ability to build up trusting relationships and on communication skills. As McIntosh (1988) has pointed out, visiting

clients in their own homes has important implications for the nature and management of professional-client interaction. The service offered by the health visitor may not seem immediately relevant and her presence in the home is frequently unrequested. Her acceptability is likely to be dependent on her ability to present herself as more of a "friend" than a professional advisor, and she is therefore in a position to be accepted by the client as a confidant.

Health visitors and mental health

Briscoe (1984) makes the point that health visitors are in a key position to pick up emotional problems in their clients at an early stage, and their role in screening for psychosocial disorders has been described by Clarke (1980). Frommer and O'Shea also observed that health visitors are ideally situated to identify postnatal depression.

Corney (1980) who studied referrals to social workers by health visitors, found that health visitors rarely referred clients with emotional or relationship problems, but tried to help them by providing social support, making more frequent visits, sometimes several times a week. In cases of depression, the health visitors: "would become someone the client could talk to, or someone to be there when the client cries". Health visitors would often encourage clients to ventilate their feelings, but were sometimes anxious that they would "get out of their depth". If the depression was severe, or lasted longer than expected, they would usually involve the doctor.

Health visitors and counselling

That the role of the health visitor includes counselling her clients is increasingly being recognised. Ferguson (1986) found that the majority of a sample of health visitors had a working knowledge of the principles underlying the counselling relationship, and regarded counselling as part of their job, although they recognised their need for additional counselling skills training. Cox (1987) describes the use of videos to teach counselling skills to health visitor students, and Burnard (1987) favours an experiential approach.

Health visitors' relationship with new mothers

An important factor in deciding on an intervention was that help should arrive rather than needing to be sought. Health visitors are routinely involved in the care of postnatal mothers, and are already familiar to them. As Briscoe and Williams (1985) pointed out, health visitors are also unique among health professionals in that they initiate contact with their clients. They also have continuing contact, which means that after the intervention is over, the relationship will still be there.

HYPOTHESIS

All these considerations led to the precise hypothesis that health visitors given information about postnatal depression and a brief training in non-directive counselling could help women to recover from postnatal depression, and that such recovery would be reflected in a reduction in scores on standardised measures of depressive illness.

METHOD

Introducing the study to doctors and health visitors

It was important to design a structured programme which the health visitors could implement without undue disruption to their working routine. At each stage the aims of the project were outlined to the health visitors themselves and to the nursing officer in each health centre, and also to the doctors and other personnel with whom they were working. The views of everyone concerned and especially those of the health visitors were taken into consideration in planning the programme. The work progressed gradually, with one health centre at a time becoming involved, and the research in any particular health centre did not start until we had the agreement of all the relevant personnel, and until all the health visitors working in the health centre had given their informed consent to participation in the project.

Preliminary talks were given to the personnel of six health centres, three in Livingston, a new town 17 miles from Edinburgh, and three in Edinburgh itself. The health visitors in five health centres agreed to take part in the study; in the sixth the doctors (one of whom was also a psychiatrist), were already working with the health visitors to provide a preventive and treatment programme for mothers with postnatal depression, and did not wish to take part in the study.

Seventeen health visitors participated in the study. The first health centre to become involved had been the setting for the validation of the Edinburgh Postnatal Depression Self-Report Scale (Cox, Holden, Sagovsky, 1987). The interest of the health visitors working here was a great encouragement in our decision to test the hypothesis health visitors given information about postnatal depression and a brief training in non-directive counselling could help women to recover from postnatal depression, and that such recovery would be reflected by a reduction in scores on standardised measures of depressive illness.

Rationale for the training programme.

My first aim was to provide the health visitors with brief training programme which would give them a clearer understanding of the nature of postnatal depression and of the underlying principles and practice of non-directive counselling, and to provide them with a structured approach to helping the depressed mothers. A preliminary questionnaire revealed that even more recent health visitor training courses had included only rudimentary information about postnatal depression, and that most health visitors had been told about the work of counsellors, rather than about counselling itself.

Although most health visitors consider that much of their time is already devoted to counselling (Gillies, 1983), many are oriented towards active intervention rather than the more passive approach required for non-directive counselling. Every health visitor is first trained as a hospital nurse, where specific and clearly defined activities alleviate discomfort and tangibly speed the patient's recovery. Their accustomed role is that of an expert on health matters, and in situations which call for counselling the health visitor may believe that she should direct her energy towards seeking solutions to the problems of her clients.

My second aim therefore was to convince the HVs of the value and importance of active listening rather than giving opinions or suggesting any specific course of action. The time allowed for training of the health visitors was brief; I only had three weekly one-and-a half hour sessions in which to convey this very important message.

Training

The health visitors were taught in small naturally-occurring groups according to their work-place. The smallest group was three health visitors and the largest was five. The small group size allowed for an intimate atmosphere, with maximum participation and discussion.

Each health visitor was given a manual prepared by the author (see appendix) in which the theory and underlying principles of non-directive counselling were explained, based on the writings of Carl Rogers. The manual also contained guide-lines for counselling practice, drawn from the personal experience of the author, interpersonal communications with other counsellors and from extensive reading. A description of postnatal depression was also included.

The manuals were sent to the health visitors two weeks before training started, to give them time to read and reflect on the material. The training sessions for the first group of health visitors were carried out by myself supported by the research psychiatrist R.S., who also helped with the making of the videos, and checked the content of the manual of instructions. The four subsequent groups of health visitors were taught only by myself.

Training the health visitors

The training sessions took place on the same day of three consecutive weeks, to allow time for reflection and the formulation of questions about the material presented; the time interval also provided the opportunity for individual health visitors to practice counselling with appropriate clients in their case-load. Each health visitor was given the opportunity to describe a counselling session and any difficulties experienced were discussed by the group.

The first session.

In the first session, the health visitors discussed their own knowledge and experience of postnatal depression and counselling, and were shown a video of a group of mothers discussing their subjective experience of postnatal depression. The symptoms and implications of postnatal depression were discussed, as were issues arising from the needs expressed by mothers in the video, and from cases known to the health visitors themselves. For "homework" during the intervening week, the health visitors were asked to read about non-directive counselling in the manual.

The second session.

In the second session we discussed non-directive counselling and the importance of effective listening, illustrated by a video made with the help of the research psychiatrist, which illustrated some of the difficulties of non-directive counselling in the health visiting situation. This video was designed to pose questions to which the health visitors were encouraged to think of solutions, rather than attempting to provide them with a "role-model" for non-directive counselling. The scene presented is that of a counsellor sitting with a mother who is feeding her baby. The mother uses the baby as a distraction and leads the counselling health visitor into a discussion of immunisation and infant feeding. How would the health visitor cope with such a situation and encourage the mother to talk about herself and her feelings?

Other important points raised were the style of the counsellor, counselling techniques including eye contact, use of encouragers, the reflected question, and the use of silences. After discussing these points and any others raised by the health visitors, they were then encouraged to participate in role-playing a situation where one acted as the mother, the other taking the part of the counsellor. The health visitors were also asked to practice non-directive counselling with a client in their case-load during the intervening week.

The third session.

The third session started with a discussion of any problems encountered by the health visitors in the course of their counselling sessions with clients. The main theme of this session was how to deal with the feelings aroused by counselling, including distress expressed by clients, and the response of the counsellor. The health visitors

had indicated that this was an area with which they often felt inadequate, and that they felt more comfortable in attempting to cheer people up rather than encouraging them to express their sadness. A third video was presented, in which a counsellor facilitates a tearful mother in the expression of her emotions, and this was discussed in detail. Questions for discussion included questions such as why do we feel uncomfortable if someone cries, and what is the most helpful response to a client's distress in a counselling situation?

THE FIRST COUNSELLING INTERVENTION IN THE STUDY

This record was compiled from reports by the health visitor of the counselling sessions, interview data on depression, and transcribed material from a tape-recorded interview with the client. Discussion of this first counselling exercise helped us to recognise the problems which may be encountered by health visitors in offering counselling to mothers and to formulate guidelines for presentation of the service. It also illustrated the need for support and back-up in the initiation of changes in service practice.

This client had many problems, and had previously regarded health visitors as representing authority. Although she remained depressed, both she and her health visitor reported positively on the experience.

Age: 37, 4th baby, a boy, two older girls aged 17 & 19, and a boy aged 16, all living at home. No improvement in depression. No contact with family doctor during the study period.

Housing:

Modern council house, own garden, in a new town where she has lived for 8 years. A sister lives near and the rest of her family live in Glasgow.

Background:

Separated from the father of her older children six years ago, although she still saw him and they remained good. Her relationship with the father of her baby is recent. When counselling began, he was in prison.

The research team identified the depression and asked the health visitor to commence counselling. The health visitor had been concerned, because the client spent most of the day in her dressing gown and rarely went out. She also appeared to have little interest in her baby, leaving its care to her sister, with whom she was staying. The health visitor had met the client antenatally and felt that non-directive counselling would not be easy. Before counselling started, she had encouraged the client to go back to her own home to see if she could gain confidence in caring for the baby herself.

The health visitor's experience of counselling:

The many problems experienced in this "test case" gave us useful guidelines for the instructions to counselling health visitors. The first difficulty was that many unsuccessful visits were paid before contact was made. The client seemed to avoid her health visitor, but at last agreed to see her.

At the first and second visit, the health visitor experienced a conflict between her respect for the client's right to control her own environment and the need to establish a setting conducive to

counselling. The TV was on, and at least one teenager was present during the interview. The health visitor felt that the client used their presence and the TV as a barrier to communication. Another source of confusion existed between the attempted role of counsellor and Fiona's expectation that her health visitor would give specific advice.

After discussing these problems with the research team, it was decided that the best strategy was to negotiate a "contract" in which the health visitor would offer a special service, with the understanding that the mother would cooperatively receive it.

The health visitor explained that talking about feelings is helpful for depression, and that for the next few weeks, she would come to listen, rather than to talk. The importance of a quiet atmosphere was stressed, with the baby being cared for or asleep during "counselling time". A trusting relationship was gradually built up, and by the third visit the client was dressed and waiting at the appointed time.

The client had heard that the baby's father had a "split personality and sought reassurance as to whether that her baby would inherit this. It is clearly inappropriate for the counsellor to maintain a passive role in the face of such a clearly defined anxiety, so a medical opinion was sought, and the client was reassured.

In spite of the problems encountered, the health visitor recorded that "non-directiveness really works". She claimed that it felt very different from her usual role, and found that listening without seeking solutions led to deeper insight into Fiona's problems and motivations.

For example, she had assumed that the client had stayed at her sister's house because she didn't feel able to cope on her own. It emerged that the real reason was that the baby's father was not in prison at this time, and she was reluctant to face him at her home. Another false assumption was that leaving the baby to her sister's care was due to lack of interest in him, whereas the client had felt unsure of her ability to care for a baby after the long interval.

Conclusions from 1st counselling experience:

Although the client remained depressed, it seems clear that she benefitted from the experience, and that her changed perception of the health visitor's role enabled her to feel that help would be available should she need it in future. The client and her health visitor provided useful feedback for the way in which this counselling service should be introduced to clients.

It was decided that the health visitors should explain on their first counselling visit that their role would be different from their usual one. They were asked to tell the mothers that talking is a useful

therapy for depression, that for eight regular weekly half-hour sessions they would have an opportunity to talk about themselves and their feelings, and that this time would be specifically for them.

Health visitors were asked to say that during this time they would not do much talking, and would, as far as possible, avoid giving advice. However, it was explained to health visitors that in cases where a specific worry could only be resolved by direct reassurance it would obviously be counterproductive to withhold such reassurance. The health visitors would explain that although they would still be available to discuss baby care or other practical matters, such discussions would be kept separate from the counselling session.

It was also decided to ask mothers where possible to arrange to have privacy, asking a neighbour, friend or husband to look after the other children during this time. Without this "permission", many mothers would not feel that their own needs were sufficiently important to seek time for themselves. If privacy could genuinely not be met at home (for instance, when living in crowded conditions, or with in-laws) the mother might be invited to come to the health centre to see her "counsellor". Wherever possible, however, help was delivered to the home, as it is often difficult for depressed mothers to organise themselves sufficiently to get out of the house.

It was also stressed as important that a regular appointment should be made wherever possible. The mothers were in fact, being offered a specific investment of health visitor time, and it was considered that if a "contract" was made, they would be more likely to respond with a commitment of their own.

Instructions for counselling.

The health visitors were asked to make a formal "contract" with mothers in the counselled group to visit once a week for 8 weeks. They were asked to explain that talking about feelings is helpful for depression, to make a regular appointment so that the mother could arrange to have privacy, and to spend at least half-an-hour listening to the mother without giving instructions or advice. Questions about baby care or routine health matters were to be discussed at a separate time. The health visitors were requested only to give the "counselling package" to mothers we had referred. They were, however, encouraged to offer routine treatment to any mother they suspected of being depressed, including referral to the doctor or to a support group.

Instructions for administering the EPDS

The health visitors were asked to give the EPDS to all mothers at the 6-week clinic visit. The EPDS forms were put into the envelope and sealed by the mothers. The health visitors did not see the scores.

MEASURES USED

1) The Edinburgh Postnatal Depression Scale. (EPDS, Cox, Holden, Sagovsky, 1987).

This self-report scale was designed for use in community surveys and by primary health care workers to screen mothers for postnatal depression. 21 items, some of our own construction and some derived from the Irritability, Depression and Anxiety Scale (IDA) (Snaith et al 1978), the Hospital anxiety and Depression Scale (HAD) (Zigmond and Snaith, 1983) and the Anxiety and Depression Scale of Bedford and Foulds (1978) were tested for face validity and piloted extensively in Edinburgh child health clinics. The resulting 13-item scale was then validated against a standardised psychiatric interview (Goldberg, 1979) and Research Diagnostic Criteria (Spitzer, 1972) with a sample of 63 puerperal women attending health centres in Livingston.

This validation showed that the 13-item scale distinguished clearly between depressed and non-depressed women (sensitivity 96%, specificity 91%). On rotated factor analysis 2 "irritability" items from the IDA and an item relating to enjoyment of motherhood formed a separate non-depressive factor. Analysis of the data suggested that omission of these items may further increase specificity. A 10-item scale would also have the advantage of taking less time to complete.

We therefore decided to use the scale in its 10-item form to screen women for inclusion in the present study. This also gave us the opportunity to further validate the scale against a standardised psychiatric interview and Research Diagnostic Criteria. With a sample of 84 women and a threshold score of 12/13, the sensitivity of the EPDS (the proportion of depressed women who were true positives) was 86%; the specificity, or proportion of non-depressed women who scored below threshold was 78%, and the positive predictive value, or proportion of women who scored above threshold on the EPDS and met the criteria for depression, was 73%.

The scale was also sensitive to changes in the severity of depression over time. (EPDS mean scores for women who remained depressed according to RDC Criteria were 16.5 at Interview 1 and 15.38 at Interview 2, whereas the mean scores of women who had recovered at Interview 2 were reduced from 15.8 to 9.8, $t = 3.72$, $p = .002$).

The EPDS consists of ten simple statements relating to symptoms of postnatal depression. Each statement has four possible responses, and the mother is asked to underline the response which comes closest to reflecting her feelings of the previous week. The responses are scored from 0-3, and the EPDS total score is simply a sum of all the scores.

An EPDS (scoring sheet) is shown overleaf.

EDINBURGH POSTNATAL DEPRESSION SCALE: SCORING SHEET

- | | |
|--|---|
| 1. I have been able to laugh and see the funny side of things: | |
| As much as I always could | 0 |
| Not quite so much now | 1 |
| Definitely not so much now | 2 |
| Not at all | 3 |
| 2. I have looked forward with enjoyment to things: | |
| As much as I ever did | 0 |
| Rather less than I used to | 1 |
| Definitely less than I used to | 2 |
| Hardly at all | 3 |
| 3. I have blamed myself unnecessarily when things went wrong: | |
| Yes, most of the time | 3 |
| Yes, some of the time | 2 |
| Not very often | 1 |
| No, never | 0 |
| 4. I have felt worried and anxious for no very good reason: | |
| No, not at all | 0 |
| Hardly ever | 1 |
| Yes, sometimes | 2 |
| Yes, very often | 3 |
| 5. I have felt scared or panicky for no very good reason: | |
| Yes, quite a lot | 3 |
| Yes, sometimes | 2 |
| No, not much | 1 |
| No, not at all | 0 |
| 6. Things have been getting on top of me: | |
| Yes, most of the time I haven't been able to cope at all | 3 |
| Yes, sometimes I haven't been coping as well as usual | 2 |
| No, most of the time I have coped quite well | 1 |
| No, I have been coping as well as ever | 0 |
| 7. I have been so unhappy that I have had difficulty sleeping: | |
| Yes, most of the time | 3 |
| Yes, sometimes | 2 |
| Not very often | 1 |
| No, not at all | 0 |
| 8. I have felt sad or miserable: | |
| Yes, most of the time | 3 |
| Yes, quite often | 2 |
| Not very often | 1 |
| No, not at all | 0 |
| 9. I have been so unhappy that I have been crying: | |
| Yes, most of the time | 3 |
| Yes, quite often | 2 |
| Only occasionally | 1 |
| No, never | 0 |
| 10. The thought of harming myself has occurred to me: | |
| Yes, quite often | 3 |
| Sometimes | 2 |
| Hardly ever | 1 |
| Never | 0 |

2. The Standardised Psychiatric Interview (SPI)

This standardised interview was designed by Goldberg et al, in 1979 for use in community surveys. Its use is approved only after attendance at a one-day training course has been successfully completed. The SPI is a semi-structured clinical interview which includes a four-point rating for ten defined psychiatric symptoms (examples are anxiety, depression, phobias and sleeplessness) and twelve manifest abnormalities of the mental state, including the interviewer's rating of observed depression. The total SPI score is derived by a summation of the ten symptom ratings added to twice the ratings of manifest abnormalities.

The SPI was adapted by J.C. and R.S. for use with a postnatal population, and to enable Research Diagnostic Criteria to be applied.

- 1) The questions on sleep were changed to allow for the variations in sleep patterns resulting from the infant's feeding patterns.

- 2) A full rating of depressive symptoms was made, including any change in appetite or weight, loss of interest, and suicidal thoughts.

- 3) All ratings were made on the two week period immediately before the interview, rather than being relevant to one week only.

An SPI was carried out by the research psychiatrist (R.S.) with every subject before the intervention, and repeated after an interval of 12 weeks. R.S. was trained in the use of the SPI, and individual ratings were discussed with J.C.

3. Research Diagnostic Criteria (Spitzer et al, 1975)

The SPI ratings were supplemented by a diagnosis based on Research Diagnostic Criteria, adding in the full range of depressive symptoms relating to the two weeks immediately preceding the interview. RDC classify depression into two categories; Major Depression (definite or probable) and Minor Depressive Illness (definite or probable).

Other Data collected.

- 1) Demographic and social information and a medical and obstetric history for each subject was recorded by R.S. at the first psychiatric interview. Further information was provided from medical records by medical secretaries with the permission of the doctors.

- 2) Information about each subject concerning the number of visits paid to her doctor, whether consultations had included discussion of depression, and any treatment prescribed (including antidepressants or referrals) during the study period was obtained by clerical staff from the women's medical notes. In the case of women who had received medical treatment, these data were supplemented by information

provided by the doctors after the women had completed the trial. If a women was still depressed at the end of the trial, her doctor was asked for further information a year later.

3) The health visitors were asked to complete a form for each counselling session, indicating subjects covered during the interview, the mother's current mood, whether anyone else was present, whether they felt they had been non-directive, and whether they considered the session to have been helpful. These forms also served as a reminder to the health visitors of the underlying expectations of the counselling sessions.

4) Health visitors' clerical assistants collected records of the number of home and clinic visits paid to women in both groups during the study period.

5) 3 months after the second diagnostic interview had been carried out and the results recorded, a tape-recorded follow-up interview was conducted with all women in the study. I asked the women about their depression, present and past relationship with their mother and with their partner, whether this had been a wanted baby, and how they felt about motherhood. If the partner was present, he was also interviewed.

DESIGN OF THE STUDY

1) 6 weeks postnatal: EPDS 1:

Given to all mothers at a clinic visit by their health visitor, placed in a sealed envelope by the subject, and collected weekly from the health centre. The subject was given an accompanying letter explaining the research.

2) 13 weeks postnatal: SPI 1, EPDS 2:

Administered to high-scoring mothers at a pre-arranged home visit by psychiatrist R.S. All depressed mothers were told that they were depressed, and if they agreed, they were given a visual analogue scale reflecting current mood states which they were asked to complete on the same day of each week. They were told that their health visitor may or may not come to see them, and that R.S. would contact them again and that she would come back after 3 months to see how they were progressing.

3) R.S. informed me by telephone of all depressed women.

4) I informed their doctor by letter of all women who were depressed. The letter included a request that the doctor should not mention to the health visitor that the woman was depressed.

5) Depressed mothers were allocated (by me or a secretary) to the treatment or a control group using a system of random numbers.

6) I informed the health visitor of women in the treatment group, gave her the relevant forms, and asked her to commence counselling the subject. The health visitor was NOT informed of women in the control group. If she did discover that a mother in her case-load was depressed, and suspected that she may be in the control group, the health visitor was free to take whatever action would be routine in such a case, but was asked NOT TO GIVE THE "COUNSELLING PACKAGE" to such a mother.

7) At 5-6 months postnatal: SPI 2: EPDS 3:

About 10-12 weeks after the first diagnostic interview I informed R.S. by letter that the second psychiatric interview was due. R.S. then revisited the subject to reassess the depression. R.S. was given no information as to which group women had been assigned. (See page 58; "blindness of the interviewer"). A second SPI and a third EPDS 3 were completed. Depression was assessed using RDC criteria as in the first psychiatric interview.

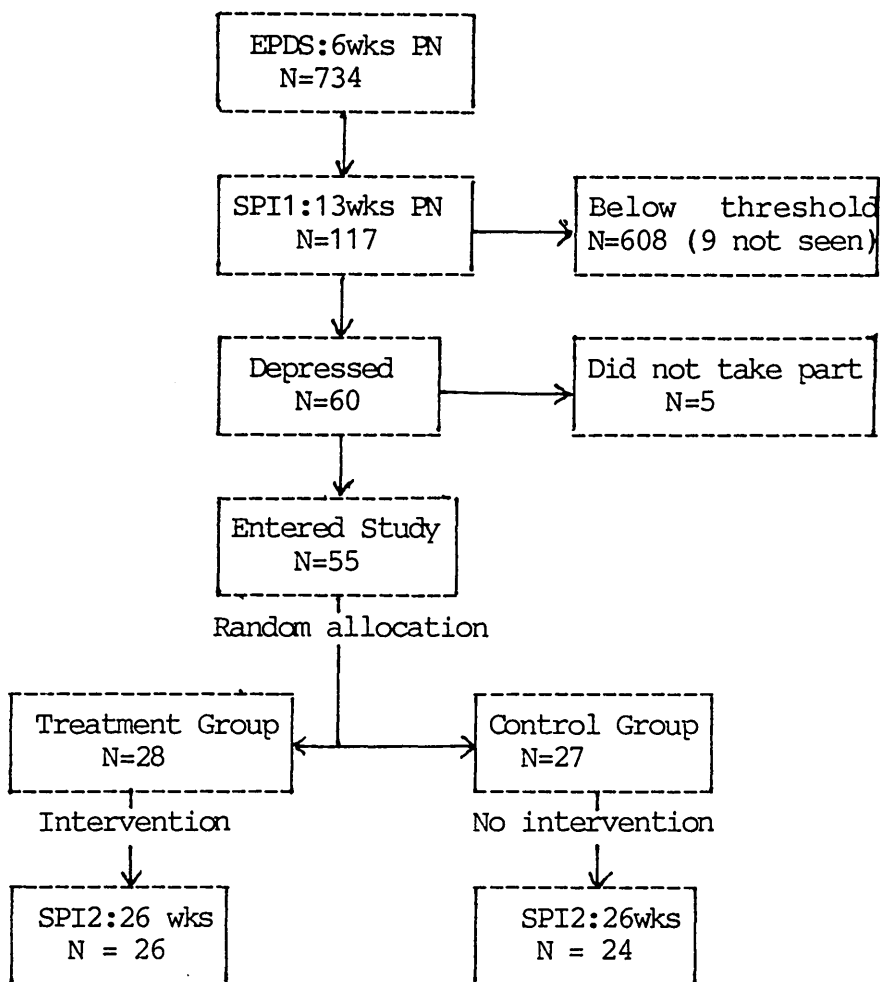
8) The doctor and health visitor were informed by R.S. about any mother in either group who was still depressed. R.S. then sent the SPI 2 and EPDS 3 forms to me and I recorded the result.

9) A tape-recorded semi-structured follow-up interview was conducted with each subject 3 months after the second diagnostic interview.

RESULTS

THE SAMPLE

As previously described, health visitors were asked to give an EPDS to women in their case-load at about 6 weeks postnatal to screen them for possible inclusion in the intervention study. Although the validation of the EPDS (Cox, Holden and Sagovsky, 1987), showed a useful threshold score of 12/13, because of the expense of arranging domestic psychiatric diagnostic interviews, 14 was chosen as a cut-off to exclude women with borderline or short-lasting depression. 22 women who scored 12-13 also had an SPI as a check that depressions in lower-scoring EPDS 1 women were not being missed.



734 women completed EPDS1 at 6 weeks postnatal, of whom 608 women had no further follow-up. 117 had an SPI at about 13 weeks postnatal (SPI1), and completed EPDS2. 57 were not depressed, including 12 with low mood insufficient for RDC criteria, 2 with phobias, 1 anxiety disorder, and 1 woman with personality disorder who scored 25 and 21 on EPDS1 & EPDS2). These women took no further part in the study.

60 women were found to be depressed at SPI1, of whom 5 were excluded; one because her husband disapproved, one was receiving psychiatric treatment, two were being cared for by social workers, and one was counselled by a psychologist. 55 agreed to participate and using random numbers, 28 were allocated to the counselled group, of whom 2 left home with no forwarding address. 27 were allocated to the control group, of whom one could not be traced, and 2 women who had been hospitalised did not wish to be reinterviewed. 50 women completed the trial, 26 in the treatment group, and 24 in the control group.

Table 1: Comparing Scores on EPDS2 with RDC Diagnosis at SPI1 for 117 women who had scored 12 or above on EPDS1 at 6 weeks postnatal.

28						
27						
26						
25		X				
24						X
23				XX		
22				X		XX
21			X	X		XXX
20			X			X
19			X		X	X
18						XXX
17	X		X	XXXXX		XX
16				X		XXXXXXXXXXXX
15			X			XXXXX
14	XX		X			XXX
13	XX		X		XXX	XX
12	X		XX		XXX	XXX
11	XXXXXX	X	X			X
10	XXXX		X		X	
9	XXXX		X		X	
8	XX					
7	XXXX	X				
6	XX	X			X	
5	XX		X			
4	XXXXX					
3	XXXX					
2	X					
1	X					
0						
-----I-----I-----I-----I-----I-----I-----						
No		Other	Low	Minor	Major	Major
Depression		Diagnoses	Mood	Definite	Probable	Definite
N = 41		N = 4	N = 12	N = 18	N = 5	N = 37
-----I-----						
Not Clinically Depressed				RDC Depression		
N = 57				N = 60		

117 women who had scored 12 or above at 6 weeks postnatal were given an EPDS and SPI with RDC diagnosis at about 13 weeks postnatal. In this sample the sensitivity of the EPDS (proportion of RDC depressed women who were true positives) was 56/60, or 93%. The specificity (proportion of non-depressed women who were true negatives) was 45/57, or 80%. The positive predictive value of the EPDS (proportion who scored 12 or more on EPDS2 and met RDC criteria for depression) was 56/71 or 79%.

Table 2: Distribution of social and obstetric factors

	Counselled (n=26)	Control (n=24)	Total (n=50)
Mean age	27.6	24.6	26.2
Primiparous	8 (31%)	6 (25%)	14 (28%)
Multiparous	18 (69%)	18 (75%)	36 (72%)
Mean number of Pregnancies	2.4	2.3	2.4
Type of delivery			
Spontaneous vertex	15 (58%)	21 (87%)	36 (72%)
Forceps delivery	5 (19%)	0	5 (10%)
Caesarian Section	6 (23%)	3 (13%)	9 (18%)
Social Class			
I & II	3 (11%)	3 (12%)	6 (12%)
III	11 (41%)	9 (38%)	20 (40%)
IV & V	12 (48%)	12 (50%)	24 (48%)
Previous depression	10 (38%)	11 (45%)	21 (42%)
Major Depression at interview 1	17 (65%)	17 (71%)	34 (68%)

The mean age of women in our sample was twenty-six years (range sixteen to forty years). Thirty-six had a normal spontaneous vertex delivery, nine were delivered by Caesarian Section and five had a forceps delivery. One baby was born at home. According to their partner's occupation, 6 were from social class 11, 20 from social class 111, and 24 from social classes 1V and V.

47 women were married or living with a permanent partner, and of the 3 who were single, one was a sixteen-year-old living with her parents, another had supportive teenage children and a third had a permanent boyfriend. 32% of the families did not have an earned income; 12 partners were unemployed, as were the 3 single women.

The counselled women were slightly older and had more obstetric complications than did controls, but parity, employment and social class were similarly distributed between the groups.

Outcome.

The overall measure of outcome was whether or not women recovered from their depression between the first and second psychiatric interview (SPI1 and SPI2), according to Research Diagnostic Criteria.

Table 3 shows the number of women in each group who showed no depression at the second psychiatric interview. (SPI 2).

Table 3: Number of women recovered at SPI2

	Counselled	Control	Total
RECOVERED	18	9	27
DEPRESSED	8	15	23
TOTAL	26	24	50

(Chi square 5.06. P =.03)

Our main finding was that eighteen of the twenty-six women in the counselled group showed no evidence of having a depressive illness at the second psychiatric interview, whereas only nine of the twenty-four women in the control group had recovered. The percentage of women who recovered in the counselled and control groups were 69.2% and 37.7% respectively. The difference, 31.7%, had a 95% confidence interval of 5% to 58%. The chi squared statistic was 5.06 with 1 degree of freedom, and an associated P value of .03.

Table 4 shows the changes in measures of depression at the first and second psychiatric interviews. The total SPI score is the sum of all scores in various categories throughout the psychiatric interview. Observed depression is the rating given by the interviewer for depression.

Table 4: Changes in Measures of Depression Over the Study Period

Within-group changes in median scores on measures of depression at diagnostic psychiatric interviews							Significance of the difference in the changes between groups	
	n	Median Score Time1	Median Score Time2	Median Change	Confidence Limit (95%)	p*	Confidence Limit (95%)	p**
<u>SPI[‡] Total Score</u>								
Counselled	26	25.5	14.0	-12.5	-17 to -07	.001	-17 to -04	.01
Control	24	24.0	23.0	-02.0	-06 to +03	ns		
<u>Observed Depression</u>								
Counselled	26	2.0	0.5	-2.0	-2 to -1	.001	-02 to 00	.01
Control	24	2.0	2.0	0.0	-1 to 0	ns		
<u>EPDS² Score</u>								
Counselled	26	16.0	10.5	-6.0	-8 to -4.5	.001	-07 to -2	.01
Control	24	15.5	12.0	-1.50	-4 to +0.5	ns		

‡Standardised Psychiatric Interview

²Edinburgh Postnatal Depression Scale

*Wilcoxon signed ranks test.

**Mann-Whitney test for independent samples.

The changes in mean scores obtained at successive interviews were tested for each group using a Wilcoxon signed ranks test. The differences between the two groups in these changes were then tested for significance using a Mann-Whitney rank test for independent samples. The counselled women showed a highly significant reduction in mean scores from the first to the second interview on all measures of depression. Although the mean scores of the control group women were also reduced, this reduction was considerably less, and did not reach significance. There was a significant difference in the amount of reduction in the measures of depression between the counselled and control groups.

Table 5: Showing the change in EPDS scores from Interview 1 to Interview 2 for recovered/non-recovered counselled and control women

	Counselled Recovered	Counselled Non-recovered	Control Recovered	Control Non-recovered
-20	X			
-15	X			
	X		X	
	X			
-10	X			
	X			
	X		XX	O
	XXX		X	
	XXX	OOO	XX	
-05	X			
	XXX	O		O
	X			O
				OOO
		O		O
OO		O	X	OO
		OO		O
			X	OO
			X	
+05	<div>X = Recovered O = Not recovered</div>			
				O
+10				
	Counselled Group N=26 Mean reduction=6.4		Control group N=24 Mean reduction=1.8	

Taking reduction in EPDS scores rather than RDC diagnosis of depression as the criterion for improvement, the difference between the treatment and control groups remains. Using a Wilcoxon test for matched samples, the counselled women showed a significantly greater mean reduction in EPDS scores at Time 1 and Time 2 than did controls ($p = .001$). (Although not significant, it is interesting to note that only 7.7% of counselled women had increased EPDS scores at Time 2 compared with 33% of controls).

Major or Minor Depression at the first Diagnostic Psychiatric Interview: association with recovery.

Research Diagnostic Criteria classify depression into four categories; Major Depression (probable or definite) and Minor Depression (probable and definite). Whether the women had major or minor depression at SPI was not a factor in recovery rate in the total sample; 56% of mothers with major depression and 50% of those with minor depression had recovered by SPI 2.

Table 6: Major or Minor Depression:Recovery Rates

	Counselled		Control		Total
	Recov	Not	Recov	Not	
Major Depression	13	4	6	11	34 *
Minor Depression	5	4	3	4	16 ns
Total	18	8	9	15	50

Significance of difference between recovery rates for treatment groups

* p = 0.02 ns = not significant

There were thirty-four women with Major Depression at the first psychiatric interview, seventeen in each group. Although women with Major and Minor Depressive Illness were similarly represented in each group, more counselled women in both categories recovered than did controls.

There was a greater improvement in recovery rate in the Major than in the Minor category of depression comparing counselled with control women. Thirteen of the seventeen counselled women (76%) had recovered by Interview 2, compared with only six of the seventeen control group mothers (35%). The difference between the groups in the recovery rate of women with Major Depression at Interview 1 was thus 41%, with a 95% confidence interval of 11% to 72%. The chi squared statistic was 5.84, with an associated P value of 0.02.

In the case of minor depression, the difference in recovery rate between the groups was smaller, and did not reach significance. Five of the nine counselled women recovered (55%), compared with three of the seven (42%) controls, a difference of only 14%, with a 95% confidence interval of -48% to 50%, and an associated P value of 0.9 using a Fisher's exact 2-tailed test.

Contacts with doctors and health visitors during the study period.

The health visitors had been asked to pay eight home visits to all women in the counselled group, and to give routine treatment to any other mother who they suspected may be depressed. The family doctors were told of all depressed mothers taking part in the study. I was interested to know how many contacts the women in each group had with their health visitor and their doctor during the study period.

Table 7. Number of contacts with HV or GP during the study period.

	Counselled		Control		Difference between the groups		
	Mean	SD	Mean	SD	Mean Diff	t	p
Number of home visits by health visitor	8.8	2.2	2.0	1.6	-6.8	12.24	0.001
Number of visits to clinic by the women	3.4	2.5	2.1	1.6	-1.3	2.22	0.05
Number of times the women consulted the family doctor	2.8	2.6	2.3	1.60	- 5	0.82	n.s
<hr/>							
Diff= Difference		SD = Standard deviation					
p = Probability		t = t-value					

There were no significant differences between the two groups in the mean number of contacts with their family doctor during the study period. There was, however, a highly significant difference between the number of home visits paid by health visitors to the women in each group. The counselled women received a mean of almost nine home visits from their health visitor, compared to a mean of only two home visits received by women in the control group. This shows that the health visitors did in fact pay the requested number of visits to women in the counselled group, and that although women in the control group were receiving attention from their health visitor, they were not given the eight week counselling input. Interestingly, counselled mothers also paid more visits to the clinic than did controls.

Medical consultations and treatment.

Although there was no overall difference between the groups in the number of visits paid to their family doctor between the first and second psychiatric interview, it was important to know whether the improved recovery rate of women in the intervention group could have been due to medical intervention. The doctors were informed by letter of all women who were depressed after interview 1, although they did not know to which group the mother had been assigned. I looked first at the number of women in each group who consulted their doctor between the first and second psychiatric interview, and then at whether their depression had been recorded by the doctor as having been discussed at any time during this period.

Table 8: Medical Consultations

	Counselled	Control	Total
Did not consult	5	3	8
Consulted, depression not recorded	9	15	24
Consulted, depression recorded	12	6	18
Total N who consulted	21	21	42
Total N	26	24	50

Women who consulted their family doctor for any reason between interview 1 & 2 were similarly represented in each group. Eight women did not consult at all, and of the forty-two who did consult, depression was recorded by the doctors as having been discussed in only eighteen cases. The remaining twenty-four women presented with physical complaints, or for contraceptive advice.

Of those who consulted, only 28% of controls discussed their depression, compared to 57% of counselled women. The difference, 29%, had a 95% confidence interval of 1% to 29%. (Chi squared = 3.5, $P = 0.06$).

Medical consultations; association with recovery

Table 9: Consultations, by group and recovery

	Counselled		Control		Total
	Recov	Not	Recov	Not	
Did not consult	4	1	2	1	8 ns
Consulted, depression not recorded	5	4	6	9	24 ns
Consulted, depression recorded	9	3	1	5	18 *
Total	18	8	9	15	50

ns = not significant

* Fisher's exact 2-tailed test, $P = 0.04$

All but eight of the women in the study consulted their family doctor at some time between the first and second psychiatric interview.

Of the forty-two depressed women who did consult their doctor, depression was recorded as having been discussed in eighteen cases. (43%). We can therefore address ourselves to the question of whether consultations with the doctor in which depression was discussed influenced recovery. I compared the rate of women who had such consultations with those who had not. Of the eighteen who consulted about depression, ten (55%) recovered; of the thirty two who were not recorded as having consulted about depression, seventeen (53%) recovered.

Such consultations were clearly not a factor in the recovery of the women in this study.

However, 75% of counselled women who were recorded as having discussed their depression recovered, compared to only 28% of controls. The difference, 58.3%, had a 95% confidence interval of 19.7% to 96.9% (Fisher's exact 2-tailed test, $P = 0.04$).

Antidepressants

In the case of any woman whose record indicated that she had been prescribed antidepressants, doctors were asked to confirm the drug and dosage, and drug dosages were checked with the research psychiatrist for their potential efficacy. The doctors were asked whether they thought the women had persisted in taking the antidepressant, and at a follow-up interview (not the second diagnostic interview) I asked women who had been offered antidepressants whether they had taken them. Table 10 shows the women in each group who were offered and were considered to have taken antidepressants in a therapeutically effective dosage and the outcome.

Table 10: Antidepressants by group and recovery.

	Counselled		Control		Total
	Recov	Not	Recov	Not	
Depression recorded					
No antidepressant	3	1	0	2	6 ns
Depression recorded					
Antidepressant					
Prescribed	6	2	1	3	12 ns
(Took effectively)	(3)	(0)	(1)	(2)	(6) ns

Twelve women were offered antidepressants during the study period, of whom only six were considered to have taken a therapeutic dosage. Of the eight counselled women who were offered antidepressants, all three who took a therapeutic dose recovered. Three of the four control group women who were offered antidepressants took a therapeutic dosage, but only one recovered.

Previous history of depression

A previous history of depression in the mother (particularly if this followed a previous delivery and/or there was a history of depression in her immediate family) has been shown to be associated with postnatal depression. (Watson et al., 1984). I was interested in whether previous depression was associated with recovery.

Table 11: Previous depression, recovery rate.

Previous depression	Recovered n=27	Not recovered n=23	Total n=50
No depression self or family	11	10	21
Family history only	3	5	8
Self only, treated by GP	5*	5***	10****
Self only, treated by psychiatrist	2*°	3°	5*°
Self, treated by GP and family history	2*	0	2*
Self, treated by psychiatrist and family history	4	0	4
* = postnatal depression ° = outpatient treatment			

Twenty-nine women had no previous experience of depressive illness themselves although eight of these had close relatives who had required psychiatric treatment for depression. Of the twenty-one women had been depressed before, nine had psychiatric treatment (seven in hospital). Seven had been depressed following a previous delivery, of whom only one had received (outpatient) psychiatric help. Only six previously depressed women also had a family history of depressive illness.

Previous experience of depression was not associated with outcome overall; although more women who had personally experienced depression recovered than those who had not (62% and 48% respectively) this difference was not significant. 57% of those with previous postnatal depression recovered.

Interestingly, all six women who had both a personal and family history of depression recovered.

Differences between the groups.

42% of the women in both groups had a previous history of depression. 27% of counselled women and 33% of controls had previous personal depression but no family history, while only 4 counselled women and 2 controls had both a personal and family history of depression.

Table 12: Previous depression by group and recovery

Previous Depression	Counselled		Control		Total n=50
	Recov n=18	Not n=8	Recov n=9	Not n=15	
No depression self or family	7	3	4	7	21
Family history only	3	2	0	3	8
Self only, treated by GP	2 *	1 *	3 *	4 **	10*****
Self only, treated by psychiatrist	2 *	2	0	1 °	5*
Self, treated by GP and family history	1 *	0	1	0	2*
Self, treated by psychiatrist, and family history	3	0	1	0	4
Total N	18	8	9	15	50*****

* = postnatal depression ° = outpatient treatment

66% of counselled women with no personal experience of depression recovered, compared with only 31% of controls, (Chi squared = 4.20, P = 0.04). Of the women with previous depression themselves but no family psychiatric history, 57% of those who were counselled recovered, compared to 37% of controls. (Not significant).

All the women with both a personal and family history of depression recovered with or without counselling, and of the women with previous postnatal depression, three of the four counselled women recovered, as did one of the three controls.

In our sample previous experience of postnatal depression and a family history of depression were not a barrier to recovery.

MULTIVARIATE ANALYSIS OF VARIANCE

Two tests (EPDS and SPI) were administered before and after the counselling intervention. The difference between pre and post scores on these tests were used as dependent variables in a multivariate analysis of variance, with treatment grouping (counselled or not counselled) as the independent variable. Factors which have been implicated in the genesis of postnatal depression, and which might also be expected to have some bearing on the progress of the illness, were included as co-variables. These were: age of mother, parity, use of antidepressants, incidence of previous depression in the mother, family history of depression, and the number of vulnerability factors (see next section). The results of this test are shown in table 13.

Table 13. Multivariate analysis of variance.

Difference in scores of EPDS and SPI at Interview 1 and Interview 2

By: Treatment Group

With: Age, parity, visits to GP about depression, antidepressants, previous depression, depression in family, and vulnerability factors.

WITHIN CELLS Regression

<u>Test:</u>	<u>Value</u>	<u>Approx.F</u>	<u>Hypoth DF</u>	<u>Error DF</u>	<u>Sig. of F</u>
Hotellings	.33903	.94445	14.00	78.00	.517

Regression analysis for WITHIN CELLS error term

Dependent variable.. .. EPDS1 score - EPDS2 score

<u>COVARIATE</u>	<u>B</u>	<u>Beta</u>	<u>S.D.</u>	<u>t-Value</u>	<u>Sig. of t</u>
Mother's age	.10421	.12125	.160	.652	.518
Parity	-.71843	-.20576	.624-1	.151	.257
Visits to GP	-1.34697	-.42955	.664-2	.028	.049
Antidepressant	2.75491	.392231	.4561	.892	.066
Previous depr.	1.17667	.18156	1.069	1.101	.277
Family history	2.02746	.184181	.6751	.210	.233
Vulnerability	.00067	.00030	.360	.002	.999

Regression analysis for WITHIN CELLS error term

Dependent variable .. SPI Total score - SPI2 Total score

<u>COVARIATE</u>	<u>B</u>	<u>Beta</u>	<u>Std. Err.</u>	<u>t-Value</u>	<u>Sig. of t</u>
Mother's age	-.27362	-.14054	.387	-.706	.484
Parity	.54083	.06838	1.514	.357	.723
Visits to GP	.72093	.10149	1.610	.448	.657
Antidepressant	-2.21575-	.139263	.531	-.627	.534
Previous depr.	1.33195	.09073	2.592	.514	.610
Family history	-2.76312	-.11081	4.063	-.680	.500
Vulnerabililty	-.02276	-.00447	.873	-.026	.979

EFFECT .. Treatment Group

<u>Test Name</u>	<u>Value</u>	<u>Approx.F</u>	<u>Hypoth.DF</u>	<u>Error DF</u>	<u>Sig. of F</u>
Hotellings	.34983	6.99652	2.00	40.00	.002

Univariate F-tests with (1,41) Degrees of Freedom.

<u>Variable</u>	<u>Hypoth.SS</u>	<u>Error SS</u>	<u>Hypoth.MS</u>	<u>Error.MS</u>	<u>F</u>	<u>Sig.</u>
EPDS1-EPDS2	325.666	963.522	325.666	23.501	13.858	.001
SPI1 total	1365.742	5665.147	1365.742	138.174	9.884	.003
-SPI2total						

CONSTANT

	<u>Value</u>	<u>Approx.F</u>	<u>Hypoth.DF</u>	<u>Error DF</u>	<u>Sig. of F</u>
Hotellings test	.06485	1.29701	2.00	40.00	.285

MULTIVARIATE ANALYSIS OF VARIANCE

Using Hotellings test, the effect of the counselling on the differences in scores on the two tests, allowing for any contributions from the co-variates, was significant ($p = .002$). Separate univariate F tests on the changes in EPDS scores and in SPI scores were also significant, with associated probability levels of $p = .001$ and $p = .003$ respectively.

The regression analysis shows that none of the co-variates had a significant effect on the change in scores on the SPI. For the changes in pre and post EPDS scores, one variable, [GPD] (visits to GP relating to depression) had a marginally significant association with the change in EPDS score ($p = .049$). There was a slight tendency for the 18 women who had made more visits to their GP about their depression, to have a greater decrease in their EPDS score.



VULNERABILITY FACTORS

Three months after the second psychiatric interviews had been completed and the diagnoses recorded, I conducted semi-structured tape-recorded follow-up interviews, primarily to ask what the women's response had been to being depressed and to participating in the study. Although these were not "life event" interviews, the women spoke freely about their relationship with their partner and their immediate and extended family. It became clear that many of the women in our sample were lacking in social support and had other disadvantageous factors that have been associated with depression. For example, 19 (38%) of the mothers in the present study had either lost their mother, spent part of their childhood in care, or had been the victims of parental neglect. This figure is very similar to that found by George Brown; 36% of depressed women in his Islington sample had suffered in this way. Both Brown (1985) and Frommer and O'Shea (1973) showed that parental deprivation during childhood is an important vulnerability factor for depression.

Not surprisingly, my data also indicated that many of the women in our study had a number of the vulnerability factors which had been found by other researchers to have an association with postnatal depression. As discussed earlier, these include a previous history of depression, (especially postnatal), abortion or miscarriage (Blair et al 1970, Playfair and Gowers, 1981), an unwanted pregnancy, marital conflict or disharmony (Kumar and Robson, 1984). Brown and Harris's (1978) finding of the lack of a confidant in depression has been corroborated by other researchers. Campbell, Cope and Teasdale (1983) Costello (1982) Solom and Bromet (1982) Paykel, Emms, Fletcher and Rassaby (1980) I wondered whether such vulnerability factors may also affect recovery from depression; were women with a number of factors less likely to recover?

I was constrained by the design of the study from collecting the vulnerability data prospectively. However, although the information was obtained post hoc at a time when the treatment categories of the subjects were known to me, the women's data numbers and names were kept separately. The list of interviews due was kept according to name only, and while I was familiar with the data numbers, these were not linked in my mind with the women's names. Even so, the questions I asked usually revealed which group the woman was in, and this would have been the case even had a separate interviewer been employed. Nevertheless, I thought it would be interesting to see whether there were any obvious differences between recovered and non-recovered women in our sample, and whether, as Hadley and Strupp (1976) suggested in their review of psychotherapeutic interventions, we could attempt to:

"... examine the question of whether there are specially complex disorders that yield only to sophisticated expert interventions as opposed to the simpler force of an especially humane interpersonal encounter".

The Vulnerability Factor Index

I compiled a vulnerability factor index using data collected from the first SPI interviews, information provided by doctors and health visitors, and information from the follow-up interviews.

Factors included previous depression, previous miscarriage, abortion or stillbirth, and whether the present baby had been unwanted (to the extent that the woman said she had considered abortion). Caesarian section was included, as was having had a forceps delivery or other obstetric complications. Another factor was having a constantly crying or a "sick" baby (which had required considerable medical attention or hospital treatment).

Relationship problems included having an extremely unsupportive, absent or alcoholic partner, the woman's own mother having died, in childhood or more recently, childhood spent in care, an unsatisfactory relationship with her mother at the present time, and the absence of any close confiding relationship with either with the partner or a friend.

Social factors included no earned income, another child or children under school age, and living in an upstairs flat. (High-rise living was not a problem for most of the women in our sample, 70% had either a ground floor flat or a house with a garden). Age over 31 and more than three pregnancies were also included, as was being a first-time mother. A score of 1 was allocated to each vulnerability factor, and the total mean scores for each of the four sub-groups were compared.

Relationship problems (as described by the mother, her health visitor or her doctor) included having an extremely unsupportive, absent or alcoholic partner, or an unsupportive, absent or dead mother, and the absence of a close confiding relationship either with the partner or a friend. Childhood problems included prolonged or periodic separation from the family home or a childhood spent in care. Financial or housing problems were also included, for instance, high-rise living, or having extremely bad relationships with neighbours to the extent that the mother was afraid to go out.

A score of 1 was allocated to each vulnerability factor, and total mean scores for each of 4 sub-groups were compared.

These sub-groups were;

- 1) counselled/recovered
- 2) counselled/still depressed
- 3) control/recovered
- 4) control/still depressed.

Table 11 (overleaf) shows the vulnerability factors used, and the number for women in each of these categories.

Vulnerability Factors

1) Relationship factors

- a) No confidant.
- b) Mother dead.
- c) Current poor relationship with mother.
- d) Childhood spent in care.
- e) Partner absent or unsupportive.

2) Obstetric and social factors

- f) Previous miscarriage or stillbirth.
- g) Previous abortion.
- h) Considered abortion this pregnancy.
- i) Complicated delivery.
- j) 3 or more pregnancies.
- k) First baby.
- l) Other child(ren) under 5.
- m) Sick or constantly crying baby.
- n) No earned income.
- o) Upstairs flat.
- p) Moved house around time of birth.
- q) Age over 31.
- r) Previous depression treated by psychiatrist.
- s) Family history of depression (needing psychiatric care).

Number of vulnerability factors of each woman in the study

<u>Counselled/ Recovered</u> <u>N=18</u>		<u>Counselled/ Not recovered</u> <u>N = 8</u>		<u>Control/ Recovered</u> <u>N = 9</u>		<u>Control/ Not Recovered</u> <u>N = 15</u>	
043	0	019 bijq	4	012 ck	2	039 lr	2
003 afj	3	001 ehjng	5	046 ik	2	002 al	2
015 lmrs	4	032 cfikmo	6	028 fjm	3	053 elp	3
051 lfij	4	009 abfikqr	7	022 acko	4	017 kops	3
014 acik	4	048 aceimkp	7	005 lcjqr	5	030 kmno	4
024 kifh	4	050 acjnols	7	041 cdfimo	6	027 eknmt	5
045 aols	4	052 aceikpr	7	034 abdijlnp	8	013 afjls	5
047 qjim	4	026 aehjnqrs	8	018 aefhqjrs	8	037 abfjs	5
020 abkqos	6			023 acdegjmpl9		049 acilr	5
036 acegjl	6					008 acjnop	6
038 ekmoip	6					021 aeijol	6
029 aikmo	6					007 abeljnp	7
016 cdelmno	7					033 fhjmnog	7
006 cfipjrs	7					035 abdikno	7
004 abdglhrs	8					042 acfknrqp	8
025 abfjnpqr	8						
010 aefhjnp9							
011 cefiknors9							
<u>Total</u>		<u>Total</u>		<u>Total</u>		<u>Total</u>	
99/18 = 5.50		51/8 = 6.4		47/9 = 5.2		75/15 = 5.0	

Did the number of vulnerability factors affect recovery?

Since vulnerability factors are known to influence the likelihood of postnatal depression, it would not be unexpected that they may affect the probability of recovery. I was interested to know whether there was any difference in the number of vulnerability factors between recovered and non-recovered women, or between counselled and control women.

Table 15a: Number of vulnerability factors in recovered/ non-recovered women.

	n	Mean	SD	t	p
Recovered	27	5.33	2.48	0.23	0.817
Not recovered	23	5.48	1.81		

Using a 2-tailed Student's t-test, there was no difference in the number of vulnerability factors in recovered and non-recovered women.

Table 15b: Number of vulnerability factors in counselled and control women.

	n	Mean	SD	t	p
Counselled	26	5.69	2.19	0.99	0.328
Control	24	5.08	2.16		

Again using a 2-tailed Student's t-test, there was no significant difference in the number of vulnerability factors between counselled and control women.

From the above tables it can be seen that the number of vulnerability factors as I measured them did not affect the recovery rate of counselled women in our sample.

Table 16: Percentage and number of women with vulnerability factors

Vulnerability Factor	Couns/ Recov n=18	Couns/ Not Recov n=8	Control/ Recov n=9	Control/ Not Recov n=15	Total Sample n=50
Mean Age	24.6	31.1	25.9	24.3	26.2
No confidant	50%(9)	63%(5)	44%(4)	53%(8)	52%(26)
Mother dead (in childhood)	17%(3) 6%	25%(2) 12.5%	11%(1) 11%	20%(3) 20%	18%(9) 12%(6)
Mother unsupportive	28%(5)	50%(4)	56%(5)	33%(5)	38%(19)
Childhood in care	11%(2)	13%(1)	22%(2)	7%(1)	12%(6)
Partner unsupportive	28%(5)	50%(2)	22%(2)	27%(4)	26%(13)
Miscarriage/stillbirth	39%(7)	25%(2)	33%(3)	27%(4)	32%(16)
Previous abortion	11%(2)	0	11%(1)	0	6% (3)
Considered abortion.	11%(2)	25%(2)	11%(1)	7%(1)	12%(6)
Complicated delivery	44%(8)	63%(5)	22%(2)	20%(3)	36%(18)
3+ pregnancies	39%(7)	50%(4)	33%(3)	33%(5)	38%(19)
First baby	28%(5)	38%(3)	33%(3)	27%(4)	30%(15)
Child(ren) under 5	39%(7)	13%(1)	44%(4)	47%(7)	38%(19)
Sick/crying baby	39%(7)	25%(2)	22%(2)	27%(4)	30%(15)
No earned income	33%(6)	38%(3)	11%(1)	40%(6)	32%(16)
Living in flat	33%(6)	25%(2)	33%(3)	33%(5)	32%(16)
Age over 31	28%(5)	50%(4)	22%(2)	13%(2)	26%(13)

Marginally more counselled/non-recovered women lacked a supportive partner, had no-one in whom they could confide, were first-time mothers, had delivery complications, and were over 31 than the other mothers in our sample. However, the numbers in each cell are very small, and using a Fisher's Exact statistic, there were no significant differences in the distribution of individual vulnerability factors between the sub-groups.

Validity and reliability of the measures used.

The Standardised Psychiatric Interview of Goldberg et al (1970) was selected because its reliability has been well established, and it is one of the most respected and widely used instruments in research studies of this nature. As far as its validity is concerned, Goldberg pointed out that:

"Since for most psychiatric disorders there are no objective standards by which clinical measures can be compared, examination by an experienced psychiatrist remains the best available method of case identification. Such expert judgements will be more authoritative if substantial agreement can be shown to exist between two or more clinicians working independently, but the issue then becomes one of reliability rather than validity".

It would be clearly impracticable for two psychiatrists to interview the same client in order to compare opinions in a domiciliary setting. However, SPI interviewers are required to attend a standardisation course, and the interviewer in this research was also a senior psychiatric registrar. Validity of the psychiatric diagnosis was further confirmed by discussion of individual ratings with psychiatrist J.C. Questions on the SPI relating to somatic symptoms were modified to suit a postnatal population, particularly those relating to fatigue or sleep disturbance due to the baby.

The diagnosis of depression was further validated by using the Research Diagnostic Criteria of Spitzer et al., (1975) adding in the full range of depressive symptoms, and taking a time span of the two weeks immediately preceding the interview to rule out short-term depression. Our subjects were in fact rigorously screened; most had scored above 14 on the EPDS and as the psychiatric interview followed a mean of six weeks after the first EPDS, women who were accepted into the study had shown depressive symptoms for at least six weeks.

The EPDS validation showed that a threshold score of 12/13 identified all 21 of the women who had Major Depressive Illness according to Research Diagnostic, and three of the four with Probable Major Depressive Illness. (Cox, Holden and Sagovsky, 1987). It acted as an effective screen in the present study, and was administered on a further two occasions, at the time of the first and second diagnostic interviews. This was done partly to have an additional source of information on the subjects, and partly to gain more information about its relationship to the other measures used.

In fact, as we have seen, a very similar set of results would have been obtained had the EPDS been used as the sole criterion for determining depression. If a score of under 12 on the EPDS had been the criterion for recovery, 38 of the 50 mothers would have been placed in the same recovered or non-recovered category. 11 of the twelve remaining scores were clustered around the criterion score (between 8 and 14). The product moment correlation between the SPI 2

score and EPDS 3 (given at the same time) was 0.73 ($p = 0.001$). These findings were an encouraging confirmation of the validity of the EPDS as a measure of depression.

Notes on the "blindness" of the interviewer.

Reliability of the findings of the counselling study hinges on the blindness of the psychiatrist in the second interview as to which group the women had been assigned. Had the interviewer not been "blind", she would have been in a position to influence the assessments of depression.

No information about the assignment of women to groups was divulged to the interviewer during the course of the study, and our zeal to maintain blindness was carried to the length that we avoided meeting socially in case any clue should inadvertently be given.

There remains the possibility that blindness could be broken during the interview, as the women may have mentioned the fact that they had been visited by their health visitor since the previous interview. However, it is not surprising to me that the interviewer did not know which group the women were in, for the following reasons:

- 1) At the beginning of her second diagnostic interview the psychiatrist specifically asked the women not to discuss their health visitor. Her first words to them on entering the house were: "You can tell me anything you like, but I don't want you to say anything about your health visitor".
- 2) No questions were asked about health visitor contact during the interview.
- 3) It is usual for postnatal women to receive routine visits from their health visitor. If women did mention that their health visitor had been to see them, this would not necessarily mean that they were in the treatment group.
- 4) The women in both groups had been told at the first interview that their health visitor may or may not come to see them.
- 5) The interview was confined to the format laid down by the Standardised Psychiatric Interview of Goldberg et al (1970), designed for use in community surveys.
- 6) Difficult ratings were discussed with the research psychiatrist J.C. who had no information as to which group women were assigned.

The interviewer indicated on the front of the SPI2 interview whether she believed the woman to have been assigned to the counselled or the control group, or whether she had no idea. In the 19 cases in which she did record a guess, she was wrong in 11 cases, and correct in 8. A further two women disclosed information which revealed their group. In

the remaining 29 cases the interviewer reported that she had no idea as to which group the women were in. It can thus be seen that in the majority of cases the interviewer was unable to hazard a guess as to which group the women had been assigned, and in the cases where she did feel confident enough to guess, right and wrong guesses were evenly distributed.

That the interviewer genuinely did not know was clear to me throughout the research. After the diagnosis from the second interview had been recorded, she would sometimes ask which group the woman had been in, and in many cases her surprise was apparent.

Both women who disclosed information which revealed the group they were in were controls. This is understandable, as both these women said: "I never saw the health visitor" showing that they could only have been controls. Women who reported that they had seen their health visitor could have been in either group.

Right/Wrong Answers in each group			
	Counselled Control Total		
No idea	16	13	29
Right	2	6	8
Wrong	8	3	11
Disclosed	0	2	2
	26	24	50

Fisher's exact on right/wrong answers: P .07

Of the total sample, (N = 50) 18 of the 26 counselled women recovered, compared with 9 of the 24 controls. The difference in recovery rate between the groups was 31.7% (95% confidence interval 5 to 58; chi square = 5.06; df = 1; p = .03). Omitting the two women who disclosed their group from the analysis, would leave an N of 48. Of the remaining 22 women in the control group, only 7 recovered. The difference in recovery rate between the groups would then be 37.2% (95% confidence interval 11 to 63; chi square = 6.68; p = .01).

Had the interviewer been able to deduce from cues which group the woman was in, and (consciously or unconsciously) adjust her assessment of depression accordingly. Had this been the case, one would expect some discrepancy between RDC diagnoses and EPDS scores which the interviewer did not see. However, the correlation between scores on the EDPS and the SPI total scores at Interview 2 was 0.79 (p = .001)

DISCUSSION

The results of this study support the hypothesis that health visitors given information about postnatal depression and a brief training in non-directive counselling can help women to recover from postnatal depression, and that this is reflected by a reduction in scores on standardised measures of depressive illness.

Our sample was small, and confirmation of our results with a larger sample would be reassuring; nevertheless, the main finding, that the counselled women tended to recover more than the controls, was statistically highly significant. The multivariate analysis shows that this improved recovery rate was not related to such factors as:

1) Depression category at the first diagnostic interview.

Mothers with Major and Minor Depressive Illness were similarly represented in both groups, and more counselled mothers in both categories recovered than did controls.

2) Medical Consultations.

Consulting their doctor was not a factor in recovery rate. However, more counselled women than controls were recorded as having discussed their depression. Since the women in both groups had been told by the research psychiatrist at the first diagnostic interview that they were depressed, one might anticipate that women who did not receive the intervention would be more likely to seek medical help, but the trend was in the opposite direction. It is possible that talking about their feelings to their health visitor may have encouraged the counselled women to confide in their doctor.

3) Antidepressants.

Twice as many counselled women were offered antidepressants as were controls, although only three women in each group were considered to have taken them effectively. All three counselled women recovered, and the one control who recovered had been referred by her doctor for counselling by a community psychiatric nurse.

4) Previous history of depression

This was not associated with the recovery rate of women in our sample.

5) Vulnerability factors

The vulnerability factor index did not show that the women who remained depressed after the counselling intervention were a different group from the women who recovered without counselling.

Vulnerability

Although the vulnerability data was collected retrospectively, women in our sample had many of the factors which have been found in previous research to be associated with postnatal depression. More than half did not have anyone in whom they could confide, nearly a fifth had lost their mother, a seventh had spent part of their childhood in care, and over a quarter had either an absent or neglectful partner. More than a third had an poor relationship with their mother, to the extent that they had little contact, and no support. One mother refused to acknowledge her grandchild because her daughter was unmarried, another had put her daughter out because she was pregnant, a third lived near but never visited. Ten of the women said their mother did not know of their depression.

It is perhaps relevant to ask why two thirds of a group of women with so many problems appear to have responded to what may be considered as a relatively small input. However, the fact that so many of the women were lacking in almost any form of support may explain the response of the counselled women to a psychosocial intervention.

While it may be argued that a third of the depressed women recovered spontaneously, all the women in our study did in fact receive a what may be regarded as a substantial intervention. Malan and his colleagues (1975) who reviewed 24 counselling studies in an attempt to discover why many clients appear to recover while on the waiting list for treatment, found that a "respectable number of clients feel helped by a single assessment interview". Women in the control group completed a self-report scale at about six weeks, were given two psychiatric interviews in their own homes, and were asked to complete a weekly visual analogue scale reflecting their current emotional state. The only difference between the groups was the counselling intervention by health visitors.

Follow-up interviews

As I have said, although the follow-up interviews were conducted at a time when I knew the groups to which women had been assigned, I did not carry this information with me at the time of visiting. Neither did the women know of my involvement with the health visitors. Some women did not even know that their health visitor was involved in the study. However, it was readily apparent that counselled women had appreciated the intervention.

One of the questions I asked was "Did you get any help when you were depressed?" If the reply was affirmative, I then asked; "Who or what was the most helpful?" Twenty-four of the twenty-six counselled women said that their health visitor had been the most help, and when asked how she had helped them, many described graphically the relief they had experienced at being able to tell someone about their feelings. Some said she had been like a friend, one described her as being like

a sister and three said their health visitor was like a mother to them. From their comments it seems clear that the opportunity to talk about their feelings provided tangible relief.

For women in the control group, taking part in the study meant at least that their depression had been recognised. Many expressed their appreciation at being asked to complete the EPDS at six weeks, and they had appreciated the diagnostic interviews with the research psychiatrist, which gave them an opportunity to talk to an understanding person about their feelings. The women in the control group were not aware of having been deprived of the intervention; the research psychiatrist had told all mothers that their health visitor may come to see them, and many of the control mothers had been visited in the routine of health visiting. However, the interviews revealed differences that are hard to quantify in the way women in the two groups saw their health visitor. Control group mothers tended to view the health visitor as being there for the baby. Although many of the control group women said they got on well with their health visitor, they were nevertheless reluctant to tell her about their feelings.

Many counselled women, on the other hand, spoke of having a new conception of the health visitors' role. Whereas previously they had considered that the health visitor came primarily to check on the baby's progress, they now realised that she was there for them. Twenty-seven of the mothers said that they would not have sought help themselves, as they did not know what was wrong, or that help was available.

The health visitors.

The aim of this study was not to give health visitors a comprehensive knowledge of counselling, merely to provide information to enable them to identify women with postnatal depression, and to offer them constructive help. Most positively on their experience of being in the study. Although at first they had been concerned about the extra time that would be involved, they found that giving out the EPDS to mothers soon became part of clinic routine, and they appreciated having a structured approach to the problem of postnatal depression. Having a "contract" with the depressed women to visit regularly relieved them of the anxiety of deciding how often to visit, and being given the instruction to simply encourage the mother to talk without trying to offer advice meant that they did not have to decide what action should be taken. Many reported that this structure meant that in some cases they actually spent less time than they would otherwise have done on the problems of a particular client, and felt that they were able to use the time more effectively. Many health visitors said they had found the non-directive technique useful in other areas of their work.

What was learned from the study.

Although many of the women in the control group said they had a good relationship with their health visitor, most indicated that they would be inhibited in telling her about their feelings, in spite of having been given the EPDS and two interviews with a psychiatrist. It seems clear that most women need to be given explicit permission and a suitable opportunity in order to be able to confide. Once trust and acceptance were established, confiding not only made a difference in terms of reduction in clinical depression, but in many cases, changed the woman's perception of the health visitor's role. The counselling was described by many mothers as having beneficial effects on their relationship with their partner, and some said that it had enabled them to talk to other people about their depression. As has been shown, more of the counselled mothers discussed their depression with their doctor, and more non-recovered counselled mothers sought help from their doctor than did controls.

The need for support for the health visitors.

This study illuminated for me the need for support to be provided for counselling health visitors, especially in the treatment of a depressive illness. I visited each health centre weekly, and discussed any queries the health visitors may have in relation to the counselling, the progress they felt they were making or problems they were experiencing. One counselled and two control group women were referred to a psychiatrist, and several more would have benefitted from psychiatric support being more readily available either to the mother herself or to the health visitors.

Antenatal education

The study also illuminated the need for more information to be given to parents antenatally about the realities of parenthood and the possibility of postnatal depression. Both mothers and fathers stressed the need for more antenatal education. Four couples parted company during the study, and two of these were in the counselled group. This needs more study, and possibly an intervention designed to include fathers, some of whom reported having felt discounted as no one had asked how they were coping.

Limitations of the study and implications for further research.

Further study would be useful to examine more closely the changes which took place in the presentation of care to the mothers by health visitors. I considered asking the health visitors to tape-record sessions with clients before and after training, to enable me to compare interactional style and content. However, introducing the counselling was in itself a new undertaking; tape-recording may not only have interfered with the counselling interaction, but would have introduced another variable.

Another way to look at the changes would be to use video-recordings of interactions before and after training, but again, this would need to be carefully set up to avoid interfering with the delicate

relationship between the counsellor and client. Such methods have been used in the training of general practitioners, where the interactions take place in a surgery setting, but not, as far as I know, in the homes of clients (see Maguire et al, 1978). However, the use of video-recordings would provide useful feedback for the trainees themselves and could perhaps be tried initially with clients in a clinic setting.

I would also like to follow up the further progress of women who took part in this study in order to determine whether the improvement in their depression was maintained, and whether their changed perception of the approachability of the health visitors proved to be enduring.

Conclusions

Although confidence in the robustness of our findings should be tempered by the small sample size, the superior rate of recovery of counselled women compared to controls has implications for the training of health visitors and for changes in the delivery of care to recently delivered mothers. From this study we learned that a structured approach to the problem of postnatal depression can have a considerable impact on the lives of women with postnatal depression. Firstly, they can be identified. The EPDS is a demonstrably useful tool. It was readily accepted by mothers and its administration was incorporated into clinic routine. Depressed women expressed relief at being asked to complete the EPDS.

Secondly there was the impact of the intervention on the women. Even non-recovered women expressed their appreciation, and some had been enabled to seek help from others people. More counselled women sought help from their doctor than did controls. This echoes a comment by Bergin (1974):

"The purpose of psychotherapy is not to exclusively provide that which cannot be provided in the "ordinary environment, but to enable the client to take advantage of what help there is, by removing the obstacles within the client".

Thirdly, we have seen from the literature that postnatal depression affects the whole family. From the results of this study, it seems that families would benefit from health visitors being given a simple training in the recognition and treatment of postnatal depression.

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MANUAL OF INFORMATION ABOUT POSTNATAL DEPRESSION

AND NON-DIRECTIVE COUNSELLING

WHICH WAS PREPARED FOR

THE HEALTH VISITORS

AS PART OF THE TRAINING PACKAGE

Jenifer M Holden, 1986

WHAT IS POSTNATAL DEPRESSION?

Postnatal depression is a depression with clinically recognisable symptoms which affects 10% to 15% of all mothers following childbirth, and can last up to a year or even longer. It should not be confused with the "blues" or weepiness which affects around 50% of all mothers during the week following delivery; nor with puerperal psychosis, which usually requires intensive psychiatric treatment in hospital.

Before about six weeks after delivery, postnatal depression is not easily distinguishable from fatigue and emotional adjustment to the new baby. In the early stages the depression may respond to simple methods of treatment such as counselling, but without help it may become chronic. However, previous research has shown that very few mothers with postnatal depression are recognised or receive treatment. Mothers may be reluctant to seek help or they may not know that help is available. Or it could be that professionals, being preoccupied with the physical health of mother and baby, do not give enough time to finding out how mothers are feeling.

Although a depressed mother may manage to cope with household routine and with the baby, her depression can affect the whole quality of family life, and may have long-term effects on the social and emotional development of children. For instance, babies learn to communicate by evoking an emotional response in those around them. A depressed mother may be slow to respond, and this can affect the baby's developing communication skills. With toddlers, lowered levels of verbal communication can lead to early problems in developing language, and later to difficulties with reading. Recent research also suggests that depressed mothers may have difficulty in exercising control, and their children may develop behavioural problems, for instance poor attention span or overexcitability. Children may also develop relationship problems, both within the family and with their peers.

Postnatal depression can have profound effects on the relationship between the mother and her partner. Living with a depressed person calls for considerable tolerance and the demonstration of continued caring, as well as a good deal of practical help. However, a mother with depression may find it as difficult to ask for or to accept the extra help and affection she needs as it is for her partner to give it.

"It is terrible, you cannae dae naething, no matter what you do, you are wrong, and it is hard to explain, but you are never right. She is awfy quick tempered, things that normally she would laugh about, she disnae. She has changed a lot. You sometimes say to yourself...is she tired of me, is she sick of me, well you do."

Many men are puzzled and hurt by what appears either to be a change in their partner's personality, or an indication of a change in her feelings towards them. Without help, the relationship may deteriorate to the point of separation. With support and information, however, the couple may find that the shared experience brings them closer than ever before.

PND can be a desperately lonely and alienating condition. To feel that one is no longer in control of one's emotions, and therefore of one's day-to-day life can be an overwhelming and even a terrifying experience, especially if it seems that no one understands. Depression is, however, an indication that something is wrong, either with one's circumstances or with one's perception of a situation as unchangeable. Being given the opportunity to talk things through may lead to new insights and to a more positive and realistic assessment of the possibility for change. Having one's feelings accepted by a non-judgemental other person can also "legitimise" the depression

HOW CAN YOU RECOGNISE POSTNATAL DEPRESSION?

Mothers with postnatal depression, although they may be aware that they need help, are frequently unable to ask for it. Sometimes it is obvious that a mother is low-spirited; you may, for instance, find her in tears. Or she may reveal an undue level of anxiety about the baby, bombarding you with questions about feeding, and so on. She may be unable to let the baby out of her sight, or to let anyone else handle it. This may be noticeable at the clinic, if you try to take the baby to put it on the scales, for instance. Or the mother may fail to show up at the clinic; this could mean either that she is unable to motivate herself to get out of doors, or even that she is confused and does not remember what day it is. She may seem to be avoiding you, not answering the door when you visit or keeping you on the doorstep, this may be because she does not want anyone to see how badly she is coping.

WHY DO DEPRESSED MOTHERS NOT TELL THEIR HV?

One reason why mothers do not confide in their health visitor could be their perception of her role. Unfortunately, some mothers still regard HVs as representative of an authority which has the power to remove the baby if it is thought they are not looking after it properly. The mother may be afraid that if she talks about her feelings, she may be judged as either "mad or bad", and therefore incompetent. As Cathy said:

"Nobody tells you about PND before you have the baby. When it happens, you feel guilty - you think it's your own fault, somehow. If you knew about it, you wouldn't feel guilty and you'd seek help. You get frightened, and you think they'll take the baby or lock you away".

It may be simply that the mother does not realise that the health

visitor is interested in her needs as distinct from those of the baby. Ann said:

"I would have liked to talk to my health visitor, but I thought she was only there for the baby; I didn't think it was her job to be interested in me."

PERMISSION TO SPEAK

It seems that people need "permission" before they can talk freely about their feelings. In answer to the question:

"Could you have told your health visitor you were feeling low?"

Julie said:

"Well, yes, I was desperate to talk to someone, but I couldn't unless she asked me".

The initiative, it seems, must come from the helper. But it is no use just asking; "Are you depressed?", we have to ask the right questions in a way that inspires trust. For instance, depressed mothers are sometimes frightened to find that they have negative feelings towards their baby. This is especially difficult to admit; certainly they need to feel that it is safe for them to do so.

An empathic approach can sometimes release a pent-up response; a perceptive health visitor said to a young mother who she believed to be depressed:

"You just haven't fallen in love with this baby, have you, my dear?"

This sympathetic question produced a flood of tears, and the girl confided that not only did she not love the baby, but that she felt suicidal.

THE EDINBURGH POSTNATAL DEPRESSION SELF-REPORT SCALE

The Edinburgh Postnatal Depression Self-Report Scale (EPDS), can act as a useful "ice-breaker". Many women in our study expressed relief at having been asked to complete the scale ; they felt that not only did this prove that others were also suffering, but that they had been given "permission" to speak about themselves. They also realised that if women with postnatal depression were being sought out in this way, then it must be a recognised condition and therefore something for which they would not be judged as being personally responsible.

SYMPTOMS OF POSTNATAL DEPRESSION

Postnatal depression varies from woman to woman in the symptoms accompanying the depressed mood, just as it varies between women in the severity and duration of dysfunction. The following are symptoms which may be experienced by depressed women.

1) Sadness or emotional lability:

A depressed mother may cry for trivial reasons, or even for no reason. She may not know herself why she is crying. However, some mothers feel sad or even desperate, without being able to cry.

2) Irritability:

The mother is frequently extremely irritable with those around her, particularly her partner. She is often unreasonably angry with her other children, and may even hit or "batter" them.

3) Loss of libido:

A woman with postnatal depression usually has little interest in sex. This lack of sexual response is often as puzzling to the mother as it is hurtful to her partner.

4) Sleep disturbance:

Depression leads to disturbed sleep patterns which are not connected with the demands of the baby; either the mother cannot sleep even though she feels exhausted, or may feel that she could sleep all day.

5) Lack of energy:

Depression can lead to a constant feeling of exhaustion.

The mother may neglect herself and be unable to cope with daily life. Conversely, she may be hyperactive, repeating tasks needlessly and becoming ritually obsessed with household routine.

6) Anhedonia:

This means a lack of the pleasure response. A depressed mother finds little pleasure in life, and does not look forward to things she used to enjoy, such as an outing or meeting friends.

7) Negative feelings towards the baby:

A mother may say that although she loves her baby, she does not "enjoy" him and cannot raise the energy to play with or cuddle him. The baby becomes a chore, rather than a pleasure, and in rare cases may be actively disliked, and at risk of being "battered".

8) Lack of concentration:

A mother with postnatal depression may find it hard to concentrate or to remember things, or feel unable to cope with simple tasks. She may have difficulty remembering what day it is, or repeat actions she has already performed. One mother had to keep remaking the baby's bottle, as she could never remember how many scoops of powder she had put in.

9) Social avoidance and agoraphobia:

The mother may avoid meeting people and not want to go out, even though she previously enjoyed an active social life.

10) Anxiety:

Some depressed mothers become extremely anxious. This may be generalised, or may lead to "panic attacks". The baby is often a constant source of anxiety, even when he/she is obviously thriving.

11) Appetite changes:

Some mothers suffer from loss of appetite, others overeat.

12) Guilt and Self-blame:

Feelings of guilt may extend to all aspects of life, leading to ruminating thoughts and despondency. Depressed mothers sometimes blame themselves, or believe that by an effort of will they could be better.

13) Suicidal thoughts:

Some mothers feel suicidal, and in rare cases, may even attempt suicide. More frequently a mother will say that although life does not seem worth living, she would not harm herself because of the baby.

14) "It wisnae me"

It will be seen that there are many possible contradictions in the symptoms of postnatal depression. The most important thing to look for is a change in the mother's behaviour from her normal self. Many recovered mothers have described feeling during their depression that they were not themselves, sometimes it even seemed that they were watching an alien presence acting their stead.

MOTHERS' DESCRIPTIONS:

"It was absolutely ghastly. It felt as if there was a physical weight inside that was dragging me down. I was pulling it around all the time, and everything was an effort".

"I have never felt like that in my life before. Nobody could speak to me because I would burst into tears at the least wee thing. I took an extreme dislike to everybody in this world except my baby. I wanted everybody to go away, I was interested in nothing".

"I just got a feeling inside myself that I didnae exist, I was invisible to everyone around. I was tired, agitated, bad-tempered. I was crying a lot... It was like an entirely different person. It was something I had never experienced before. I couldn't understand what was happening to me."

WHY COUNSELLING?

In the context of the study, "counselling" is simply another word for "listening". When we asked depressed mothers in the pilot study what they felt would be most helpful they said that above all they would welcome the chance to talk to an understanding person about how they were feeling. Completing the EPDS was followed by a home visit from the research psychiatrist to determine whether or not the mother was depressed. Asked whether they had felt this to be an intrusion, most mothers said they had found it a considerable relief to be able to talk about themselves. Some mothers we contacted a month or so after the psychiatric assessment visit to check details of data, spontaneously volunteered that they had felt better since the interview. Despite the fact that neither advice nor help had been offered, the opportunity to talk about their feelings had been a relief in itself.

Social support and having someone in whom to confide are important factors in protecting people against depression. It therefore seems logical to see whether the provision of added support and a listener would be helpful to mothers who are already in trouble. A counsellor not only acts as a professional confidant, but can also provide social support. Bichard, who described the personal experiences of depressed mothers concluded that what is most needed is support, love and someone to listen, and in her book "Reactions to Motherhood" Jean Ball concluded that: "the person experiencing stress can be helped by someone whose unconditional support is available to them".

Such support may not be available within the family. A confiding relationship with her partner is less likely when a mother is depressed. Depressive symptoms do not always evoke a caring response; the partner may himself be in need of nurturing, or may be too close to the situation to provide relief. Many mothers in the counselling study found that even if their partner or friends were supportive in other ways, it was not easy to explain their feelings.

WHAT IS COUNSELLING?

Counselling is a way of helping people who are having problems in coping with their lives or in adjusting to new and possibly stressful situations. There are many different sorts of counselling, and for the Edinburgh study we chose non-directive counselling, which is less dependent on specific techniques than is the therapeutic approach known as Behaviour Therapy.

Non-directive Counselling is sometimes known as "Person-Centred" therapy, as it is based on the idea that each individual knows what is best for them, and also that people are able to influence their own environment, rather than passively accepting whatever happens to them. Depressed people have lost the feeling of control over their lives, but may be helped to recover it given the right conditions. The non-directive counsellor is not an expert advisor, but a

listener, who provides a safe environment in which the client feels free to talk about herself and her feelings. By talking things over with a warm and interested, but non-judgemental person, the client comes to understand what things are really important to her, and gradually works out solutions to her own problems.

"I talked to her about how I felt, and she just listened. When you articulate something, it makes you think about it. It helps to sort things out, and lets you see how small they are. It made me feel better that way".

THE THEORY BEHIND NON-DIRECTIVE COUNSELLING

It is as though he listened
and such listening as his enfolds us in a silence
in which at last we begin to hear
what we are meant to be"

Lao-Tze

The concept of non-directive counselling originated in the 1940's. After analysing tape recordings of many hours of counselling sessions, Carl Rogers concluded that the most effective therapy was what he first described as "passive listening". He gradually evolved a theory to explain this finding.

SELF-ACTUALISATION

According to Rogers, people have an inbuilt motivation towards reaching their fullest potential. He believed that the "self-actualising tendency" could explain most behavioural and personality disturbances.

INTERNALISING THE VALUES OF IMPORTANT OTHERS.

Children whose parents and friends love and encourage them for their own intrinsic qualities rather than for what they would like them to be, grow up able to follow their inbuilt self-actualising drive. However, many people "internalise" the values of people who are close or important to them; for instance, parents, teachers, friends or others whose opinions they care about, and this may interfere with their self-motivation.

CONDITIONS OF WORTH

Internalisation of the values of important others starts in childhood when the parent only shows warmth when the child does as he or she wishes. The child begins to realise that in order to win the affection of those who care for him, she must act in ways of which they approve, which may involve doing things she would not spontaneously choose to do.

In moderation, this is a normal part of the socialising of children; and most people have a tolerably balanced experience, internalising to some degree the values of others, while maintaining the ability to behave according to their own wishes in many areas of their lives. People become disturbed when they have internalised the values of others to the extent that they no longer recognise their own needs, and do things to please others rather than themselves. For instance, a teenager may decide to aim for a career which is not especially suited to her abilities, because she knows that this would please her parents. This can lead to conflicts and difficulties in reaching decisions. For instance, a mother may feel that she should breast feed her baby because her partner would like her to, while at the

same time knowing that she risks her mother's disapproval if she does not bottle feed. (Granny likes to feed the baby). Because of this conflict, she becomes unable to decide what she herself feels.

It is not simply a matter of doing things to please other people rather than oneself, the values of these people have become "built-in", to the extent that the person may not realise that her decisions are not based on her own feelings. In the above case, where the mother does not feel confident in her own judgement, she may ask an "expert" (the nurse or health visitor) to make the decision for her, thus absolving her from responsibility. While this may be easier in the short term, what she really needs is help to explore her own feelings, and encouragement to believe that these are more important for her than those of anyone else.

NECESSARY CONDITIONS FOR EFFECTIVE COUNSELLING

Rogers considers that only 3 basic conditions are necessary for counselling to be effective. These are:

- 1) Accurate Empathy on the part of the counsellor.
- 2) Unconditional Positive Regard of the client by the counsellor.
- 3) Genuineness and "Congruence" on the part of the counsellor.

EMPATHY:

According to Rogers, empathy is the most important factor in therapy. He sees it as a special way of being with another person; a way which locates power within that person, rather than in the expert.

"Empathy is...to sense the hurt or the pleasure of another as she senses it."

...the ability to enter the private world of the client and feel at home in it; to temporarily live her life without making any judgements, moral or otherwise.

...sensitivity to the emotions which flow in the other person (fear, rage, tenderness, confusion or whatever).

Empathy is not just communicated verbally; body language, eye contact, and tone of voice are all important ways of communicating a "readiness to share".

UNCONDITIONAL POSITIVE REGARD.

Unconditional positive regard means the ability to communicate warmth and friendliness regardless of whether one approves or disapproves, likes or dislikes the individual concerned. Obviously, you can't expect to feel positively towards everybody, or even towards the same person on all occasions, but it is possible to acknowledge and respect each individual, while not necessarily approving all aspects of their behaviour.

CONGRUENCE

Congruence means that the counsellor should be able to be her true self, in order that the client can experience trust and confidence.

WHAT DOES THE COUNSELLOR HOPE TO ACHIEVE?

The counsellor's aim is to help the client to reach a state in which her experiences are perceived and evaluated according to her own feelings, rather than on the basis of what she imagines others would like her to do. The most important element in non-directive counselling is the relationship between client and counsellor. A good counselling relationship is one in which the client feels confidence in the counsellor as someone she can trust with her doubts and anxieties, and with whom she can discuss her feelings with an openness which she may never have experienced before. In the case of a woman with postnatal depression, this may involve talking about negative aspects of her experience of motherhood and her relationship with her partner or with the world in general. Sharing her thoughts and feelings with someone who does not appear to be shocked by them can be a considerable relief, and should help to put things in perspective.

"..It is good ...to be able to talk about your personal problems. Especially if it is something you can't say to anyone else. You feel you can't tell anybody. It all builds up inside you, and having somebody you can say anything to is a big help".

(Jane, who took part in the validation study)

Patterson has neatly summarised what counselling is and is not:

COUNSELLING IS:

- 1) Counselling is concerned with influencing voluntary behaviour change on the part of the client (client wants to change and seeks counsellor's help).
- 2) The purpose of counselling is to provide conditions that facilitate voluntary change (conditions such as the individual's right to make choices and to be independent and autonomous).
- 3) As in all relationships, limits are imposed on the client. (Limits are determined by counselling goals that are in turn influenced by the counsellor's values and philosophy).
- 4) Conditions favouring behavioural change are provided through interviews (not all counselling is interviewing, but counselling always involves interviewing).
- 5) Listening is present in counselling, but not all counselling is listening.
- 6) The counsellor understands clients; (the distinction between the way others understand and the way counsellors understand is qualitative rather than quantitative, and understanding alone does not differentiate counselling from other situations).
- 7) Counselling is conducted in privacy, and the discussion is confidential.

WHAT COUNSELLING IS NOT

- 1) The giving of information, though information may be given in counselling.
- 2) The giving of advice, suggestions and recommendations. (Advice should be recognised as such and not camouflaged as counselling).
- 3) Influencing attitudes, beliefs or behaviour by means of persuading, leading or convincing, no matter how indirectly, subtly or painlessly.
- 4) Influencing behaviour by admonishing, warning, threatening, or compelling without the use of physical force or coercion. (Counselling is not discipline).
- 5) Counselling is not interviewing. (While interviewing is involved, it is not synonymous).

(Patterson, 1974)

HOW DO I DO NON-DIRECTIVE COUNSELLING?

Non-directive counselling is an approach in which counsellors are free to develop their own style, based on their life experiences and on their own emotional development and personality. Although I prefer not to give "instructions" for actual techniques, I have included some basic guidelines which may help you to formulate your own ideas.

Non-directive counselling involves putting yourself and your own views to one side for the duration of each session. The most important thing is that the counsellor should say as little as is needed to encourage the client to talk about herself, and should avoid giving advice or even her own point of view. As most interactions consist of relatively equal amounts of dialogue, surely it must seem strange for both participants if one is expected to do all the talking? In practice, a skilled counsellor can "draw out" a client without her noticing an imbalance, only that she has been with someone who really seemed to understand.

BUT SURELY JUST LISTENING TO SOMEONE CAN'T HELP THEM RECOVER?

Being listened to with genuine attention is a rare experience in life, and talking to a counsellor is very different from talking to a friend.

"...I have plenty of friends, and I talk to them, but it's not the same. It was a great help, having a stranger to listen. She's not going to take sides. Because she's a professional, I talk to her differently, I can be more open with her. It's hard to explain, but it was really great".

HOW SHOULD I INTRODUCE MYSELF AS A COUNSELLOR?

Tell the mother that if she agrees, you will come to see her regularly for the next few weeks, and explain that the reason for your visits is to help her to find out how she feels about things by talking them through. Explain too, that you will not be giving her actual advice, but will encourage her to make her own decisions.

It will help to establish a sense of commitment on both sides if you arrange a regular time for your visits. Stress that counselling needs privacy, and ask if the mother can arrange to be on her own when you come. This will give her "permission" to view her depression as being important enough to ask for help from her partner, family, or neighbours. She may find your new role surprising; explain that you will still be available to answer queries about the baby, but that you want to keep this time specifically for her.

If you are able to see the couple together, explain postnatal depression and the value of counselling, and emphasise the importance of the partner's supportive role in his wife's recovery, giving the assurance that anything discussed in these sessions is strictly

confidential. Acknowledge that you understand he is probably having a hard time too, coping with the changes of having a new baby and a depressed wife.

THE COUNSELLING ENVIRONMENT

First and most obviously, it's important to have privacy. Ask the mother at your first visit if she can arrange for her husband or a neighbour to look after the baby and/or other children for a couple of hours each week. It may not be easy in someone else's home, but try if you can to create a warm and comforting environment in which you both feel relaxed, while at the same time maintaining a little formality. How you do this will be a matter of individual personality (hers as well as yours) but you should aim for supportive closeness rather than intimacy.

BODY LANGUAGE AND EYE CONTACT

Empathy can be communicated physically. Sit facing the mother, at a comfortable conversational distance, but not so close as to seem intrusive. Avoid direct confrontation by sitting at a slight angle, and lean slightly forward to convey interest and inclusiveness. Looking directly at the mother will show you are interested in what she is saying; however, people who are depressed sometimes find eye contact threatening, so be guided by your client's reactions until you have established a trusting relationship.

VOICE

Ideally your voice should inspire confidence and encourage the mother to relax. Speaking loudly can seem aggressive, but on the other hand if you speak too softly your client may have to concentrate on hearing what you are saying, rather than on her thoughts. Talking too quickly can produce a tense atmosphere, but if you speak too slowly, you may seem bored. Only say the minimum that is needed to enable the mother to explore her own train of thought.

HOW SHOULD I START A COUNSELLING SESSION?

Quite a useful way of getting things started is to say something like:

"How have things been going this week?"

This is an "open-ended " question, in other words, one which can't be answered simply with "Yes" or "No". Once the mother starts to talk, just listen, showing by your expression that you are interested.

ENCOURAGERS

The use of "encouragers", e.g. "Mmmhmm", or an interested nod can help the mother to continue talking, or you can encourage her to be more expansive by saying:

"Would you like to tell me more about that"

or: "How did that feel?"

THE REFLECTED QUESTION

An anxious mother may ask a lot of questions and seek your advice. It is tempting to give it, especially if you think that you know what she should do, but it is much more productive in the long term for her to work out her own solutions. To answer her question with another question may seem like avoidance, but it will help the mother to explore and develop her own resources, and will avoid her becoming dependent on the advice of an "expert."

Client: "What do you think I should do about...?"

Counsellor: "What are your choices?"

UNDERSTANDING THE MESSAGE BENEATH THE STATEMENT

It is important to realise that there are two forms of communication going on; the surface level is one of meaning, but what we say is not always a direct reflection of what we feel. Try to help the mother to find out what her underlying feelings are. Avoid reassurance, but try to understand the emotions behind what she is saying. For example, a mother may say:

"I sometimes think I'm just stupid".

Your impulse may be to reassure her by saying:

"Oh, I don't think you're stupid at all"

but to contradict her may invalidate her experience. Encouraging her to continue with her train of thought may help her find out why she thinks she is stupid. One way to do this would be to simply repeat her last word in the form of a question, e.g:

"Stupid?"

This gives the chance for further thought; she may realise that her feeling of stupidity is based on what she imagines other people's opinion to be, rather than being what she herself thinks.

WHAT IF SHE FINDS IT DIFFICULT TO TALK?

Inevitably there will be times when the client becomes quiet. You may be desperate to say something simply to relieve your own embarrassment, but try to avoid this impulse. If a silence seems to be non-productive, it can be helpful to "sum up" with your interpretation of what the mother has been saying. For instance, you could say:

"You seem to be saying that although you love your partner, you are finding it hard to show this at the moment."

Or more simply:

"You seem to have had a confusing time recently".

This shows that you are trying to understand her feelings, and gives her the opportunity to contradict your impression or to expand on what she was saying. If in doubt, keep quiet°

SILENCE

Silence can be as important a part of counselling as what is actually said. During a silence a mother may be thinking about what she has just said, or about what she is going to say next. A companionable silence can not only encourage your client to pursue her own thoughts; it is also a very powerful way of showing that you are accepting and non-judgemental of what your client is saying. By keeping quiet you are also keeping yourself and your own views to one side; you are giving her space in which to discover how she really feels. (Using silence constructively is perhaps the most difficult part of counselling).

SUPPORT

It will be hard for a depressed mother to satisfy the demands of her baby if she is lacking emotional support herself. Knowing that she has postnatal depression may be helpful; it gives the mother a "label" and therefore a legitimate reason for asking for help from other people. It may be a useful exercise for her to look at the available sources of possible support. These may include her partner, her own family, her partner's family, neighbours, friends, or professionals. The following questions may be useful.

"Who helps you when you need support?"

"Whose shoulder can you cry on?"

"Do you find it difficult to ask for help?"

"What help is available?"

A mother may also find difficulty in responding to the needs of her baby if her own emotional needs were not met in childhood. Asking her about the past may help her to understand her present responses. For instance:

"Who comforted you when you were a child?"

What did that feel like?"

Encouraging the mother to remember her own early experiences may not only help her to deal with her baby's needs, but may explain why she has difficulty in asking for help for herself.

HOW DO WE DEAL WITH OUR RESPONSE TO OTHER PEOPLE'S PAIN?

As Dorothy Rowe said, in her excellent book on depression: "In listening to another person's story, we...open ourselves to the anguish of witnessing another person's suffering". How can we help someone who is in pain? An instinctive response may be to offer comforting advice, or to say that things aren't as bad as they seem. The "there, there" response is a way of reducing our own sense of helplessness, or may be an attempt to deal with our own painful feelings.

However, the urge to apply a bandage is not very helpful to the person experiencing the pain. It can negate her experience; she may feel that you do not understand, or she may pretend that she is alright in order to make you feel more comfortable. It takes courage to share her pain, but by empathising you will legitimise her right to feel unhappy, and give her the opportunity to experience her feelings within the safety of the counselling relationship. Crying can be a release from pain, as Jackie found.

"I just burst into tears whenever I started to think about it. A couple of times I was crying when Fiona was here but it was just getting it out.

How did she respond to that?

She told me to keep crying, because I was embarrassed.

She let you cry?

Aha. She just told me to get it out of myself. I felt better after it. I had a good cry and I felt a lot better.

Do you think that was better than if she had said, "there, there, don't cry"?

If she had said that I would have been worse. I felt daft but she told me I wasn't being stupid, it was only natural. She didn't make me feel embarrassed. I felt I didn't have to hide anything now. I could just let it all come out. It did me good".

THE REALITY OF DEPRESSION

Depression can be frightening and disabling, but it is a very real experience. There are no short cuts to happiness, especially if the depression is long-standing, or maintained by adverse circumstances. Dorothy Rowe quotes from Jill Tweedie, who experienced recurring depression:

"I cannot dismiss the idea that the vision of life seen in depression has the truth in it, the bare-boned skeletal truth, and an intrinsic part of being depressed is being told that it is not

so. Reality, however terrible, is bearable if others allow its reality".

Having been depressed is not necessarily an entirely negative experience, the important thing is to feel that one has been listened to and understood. As Kathy said:

"... although it was dreadful at the time, and everything I was feeling was bad or wrong, in retrospect I am glad I went through it - another experience in life. It makes you more sensitive to other people".

TO SUM UP

Given encouragement and acceptance, the depressed mother should gradually feel able to start to explore her feelings. She may express thoughts or feelings which seem inappropriate to you, but try always to show acceptance of her right to feel the way she does. If you can keep your own ideas to one side, you will give her the chance to work out what it is she feels, and to take responsibility for her feelings. Your role is to quietly help and encourage her to do this, in whatever way seems most comfortable to you. Sometimes it may seem that progress is slow, but don't be put off, the full effect of counselling is sometimes only apparent months later. Susan had not recovered from her depression after counselling, but her experience was very different than if she had had no support.

"My health visitor came every week. I don't know what I would have done without her. Really she helped me a lot to come through this, and she definitely saved my marriage. It had got to the point where I couldn't have cared less if he had walked out the door, I actually felt that way. She never asked questions, just let me talk. It was quite difficult, you felt embarrassed as well, but after a few weeks of that, it really made you feel as if you were getting rid of it, it was actually coming away from you. Listen to the person. Let them talk. That is what my health visitor did. Being a good listener is the best way to help someone with depression".

The counselling relationship may have spin-offs in itself. Many mothers have the idea that the health visitor's role is to make sure she is looking after the baby properly. The fact that you have offered yourself as a listener may alter the mother's perception of what health visiting is for; to help people towards a positive enjoyment of health. As Carole said:

"... I didnae ken naething aboot them. I just thought they would come and see the baby, ken, to see how she is daeing. I didnae ken they would come oot and talk to you and all that."

"You think now, that the health visitor is not just there for the baby?"

"No, they are for the parents as well. You just have to ask and they will help you, or they will mention it first. What I mean is, dinnae be shy, just tell them how you feel. It makes you feel better that way. Because I could get everything oot in the open, I could tell her everything. I dae ken how I done it, I just talked openly with her."

KNOW YOUR LIMITATIONS

Counselling is not always easy, and it may be that you feel a particular case is more than you can handle on your own. Always let the GP know what you are doing, and enlist his or her support. Setting an eight-week limit on counselling is helpful to both you and the mother, in that you both know the extent of the commitment. If the mother has not recovered by the end of this time, it may be that she needs more help than you can give. The GP may decide to give antidepressants, or in some cases a psychiatric referral may be required.

CASE HISTORIES OF TWO
COUNSELLED WOMEN
WHO TOOK PART IN
THE EDINBURGH COUNSELLING STUDY

Extracts from transcribed tape-
recorded interviews with

Jenifer Holden.

Permission was given by the women to use the material for research
manuscripts or publication. The women's names have been changed.

CASE HISTORIES OF TWO COUNSELLED WOMEN

Permission was obtained from the women to use excerpts from transcribed tape recorded interviews. Their names have been changed.

SUSAN: Age 33, this is her 2nd partnership, and her 1st baby (she had a miscarriage last year). Susan is an only child, and her mother died when she was 11 months. She was brought up by her grandmother, who also died when Susan was 16. She got engaged at 17, married at 20, and was unhappily married for 13 years (with no children). Susan has had previous depressive episodes over the past 7 years, some treated in hospital. She has also been an epileptic for 12 years and is on epilin.

Susan worked as a civil servant until 4 years ago, when she gave up because of a bad depressive episode which resulted in the decision to leave her husband. Two and a half years ago she moved with her present partner to a new town 14 miles from Edinburgh, and 6 months ago the couple bought a new house with a garden. Susan's partner, who she describes as supportive and understanding, is a maintenance engineer in a local factory. Susan is a quiet person and has not formed any confiding relationships apart from that with her partner.

Susan was counselled by her health visitor for eight weeks, starting when her baby was 11 weeks old. Her depression was considered to be much improved by the second psychiatric visit, although she had not completely recovered.

Her EPDS score was 15 at 6 weeks, 12 at the first psychiatric interview, when her depression was categorised as "major probable", and 11 ("minor definite") at the second interview. A month later, her score was reduced to 8.

Susan was unusual, in that she had not seen herself as needing help. Having been depressed before, she felt she knew what was wrong, and how to cope with the depression. Nevertheless, she appreciated the visits from her health visitor and felt supported. This was her HV's first experience of counselling in postnatal depression and she felt she learned a lot from the experience of just sitting quietly with Susan and letting her talk. At the follow-up interview Susan told me:

"My health visitor came every week. I knew she was coming to see me, not the baby. I think I would have felt a bit threatened by that - but she made it clear she was interested in me, not just the baby. I found it very helpful, more on a long-term basis than any particular session. It gave me a sense of security - that if things got really bad there would be someone I could trust and go to for help. It also changed my view of what health visitors were like. I had thought they might be interfering - not someone I would go to with personal problems. But I feel if I had problems now I could go to my health visitor with them".

CATHY: Is 28 and has been married 6 years to a bookseller. The couple have lived for 3 years in a house with a garden in the new town. They have two boys aged 3 and 2 as well as their new baby girl, who was aged three months at the first psychiatric interview. Cathy had 2 miscarriages, at 14 weeks and 9 weeks, before her first son was born.

"I got very depressed after them. John, my husband, didn't know what was wrong, and he wasn't very sympathetic. One night I ran out of the house crying. It was raining. I just ran and ran, crying all the way. I got soaked. I don't know how long I was away. I felt better for it when I came back. But John just didn't seem to understand."

Cathy also got depressed after her sons were born, but again it wasn't recognised and she felt again that her husband didn't understand. But as she says; "It must have been hard for him, I couldn't even understand it myself."

Cathy was previously afraid to talk about her depression or to tell anyone how she felt, partly for fear of being misunderstood, and partly because she felt not only guilty but blameworthy. She is a religious person, but felt that her depression barred her even from this customary source of comfort.

"I thought depression was a spiritual failure. I went to church, but I felt dead inside. I still believed in God, and I still prayed, but only by an act of will."

For Cathy, depression was something she had learned to fear in childhood. Her mother had also suffered from depression. Cathy said: "I was terrified of being like her, she's had one nervous breakdown after another."

But this time Cathy's depression was recognised. She scored 18 on EPDS1 at 8 weeks PN and was visited by the research psychiatrist at 12 weeks PN, when she scored 12 and was diagnosed as depressed. She had a good relationship with her health visitor, who arranged for her to have a home help, but then left, and Cathy's 8 counselling sessions were conducted by her new health visitor. At first, Cathy had mixed feelings about this:

"I felt very vulnerable at first. I didn't know her. I felt I was putting on a front with her. We built up a relationship gradually, but it was an effort. I think it would have been easier if I had known her before. If it had been Jill, for instance. (Her previous health visitor)... My new health visitor was very quiet, and I had to do most of the talking. I felt at first that it was a strain to talk to her. I think it did help, though, more than I realised at the time. I talked to her about

how I felt, and she just listened. When you articulate something, it makes you think about it. It helps to sort things out, and lets you see how small they are".

For Cathy, the first step towards recovery was being told that she had PND.

"Being told I was depressed by Ruth helped in so many ways. It meant I could tell other people. When they asked how I was, I could tell them I was depressed. I was amazed how many people said they had had it themselves or knew someone who had. Before, I couldn't tell anyone how I was feeling. I just pretended I was fine. I thought noone would understand. But I didn't meet anyone who said I should pull myself together."

Knowing what was wrong with her gave her permission to talk about her feelings and meant that she could legitimately ask for help from others, including her family and her husband.

"My parents were very helpful. When I said I was depressed, they understood what I was going through, because of my mother's depression".

This also made her feel closer to her mother, and less frightened of being like her. She was also relieved of guilt, and this enabled her to confide in her partner.

"He's helped me a lot this time. But the main thing is, I don't feel guilty now. I know it isn't my fault. I can talk to him better than I used to.

We're closer than we've ever been. I think that's because we both know what's the matter. I can be more open with everyone, now I know it's not my fault."

Knowing she was depressed also enabled Cathy to seek spiritual comfort from the church community.

"I told my friend who is also a Christian and who I respect that I have PND. And she said she'd had it too. So I was comforted. Prayer has helped a lot. And the knowledge that people were praying for me."

Like many of the other mothers in our study, Cathy made a plea for more antenatal education on the possibility of PND.

"Nobody tells you about PND before you have the baby. When it happens, you feel guilty - you think it's your own fault, somehow. If you knew about it, you wouldn't feel guilty and you'd seek help. You get frightened, and you think they'll lock you away."